Amend **CSSB 1264** (senate committee printing) by striking all below the enacting clause and substituting the following:

ARTICLE 1. ELIMINATION OF SURPRISE BILLING FOR CERTAIN HEALTH BENEFIT PLANS

SECTION 1.01. Subtitle G, Title 5, Insurance Code, is amended by adding Chapter 752 to read as follows:

CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

Sec. 752.0001. INJUNCTION FOR BALANCE BILLING. (a) If the attorney general believes that an individual or entity has exhibited a pattern of intentionally violating a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, or deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation.

(b) If the attorney general prevails in an action brought under Subsection (a), the attorney general may recover reasonable attorney's fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action.

Sec. 752.0002. ENFORCEMENT BY REGULATORY AGENCY. (a) An appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, or deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition.

(b) A regulatory agency described by Subsection (a) may adopt rules as necessary to implement this section. Section 2001.0045, Government Code, does not apply to rules adopted under this subsection.

SECTION 1.02. Subchapter A, Chapter 1271, Insurance Code, is amended by adding Section 1271.008 to read as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this subsection in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply that is subject to Section 1271.155, 1271.157, or 1271.158. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, or 1271.158, as applicable;

(2) the amount the physician or provider may bill the enrollee under the enrollee's health benefit plan; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of the out-of-network claim dispute resolution process under Chapter 1467.

(b) A physician or provider that provides a service or supply described by Subsection (a) shall provide notice of the prohibitions described by Subsection (a)(1) in an invoice for the service or supply provided to an enrollee.

SECTION 1.03. Section 1271.155, Insurance Code, is amended by amending Subsection (b) and adding Subsection (f) to read as follows:

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; [~~and~~]

(3) services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization

of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d); and

(4) supplies related to a service described by this subsection shall be provided to covered enrollees.

(f) For emergency care subject to this section or a supply related to that care, a non-network physician or provider or a person asserting a claim as an agent or assignee of the physician or provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) a modified amount as determined under the health maintenance organization's internal dispute resolution process; and

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

SECTION 1.04. Subchapter D, Chapter 1271, Insurance Code, is amended by adding Sections 1271.157 and 1271.158 to read as follows:

Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or provider who provides health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a health care service performed for or a supply related to that service provided to an enrollee by a non-network physician or provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a network provider.

(c) Except as provided by Subsection (d), a non-network facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health

care service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) a modified amount as determined under the health maintenance organization's internal dispute resolution process; and

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

(d) This section does not apply to a nonemergency health care service that an enrollee elects to receive:

(1) in writing in advance of the service with respect to each non-network physician or provider providing the service; and

(2) with notice of the enrollee's potential financial responsibility from each non-network physician or provider providing the service.

Sec. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a health care service performed by or a supply related to that service provided by a non-network diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a network physician or provider.

(c) Except as provided by Subsection (d), a non-network diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable

copayment, coinsurance, or deductible under the enrollee's health care plan that:

(1) is based on:

(A) the amount initially determined payable by the health maintenance organization; or

(B) a modified amount as determined under the health maintenance organization's internal dispute resolution process; and

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

(d) This section does not apply to a nonemergency health care service that an enrollee elects to receive:

(1) in writing in advance of the service with respect to each non-network provider providing the service; and

(2) with notice of the enrollee's potential financial responsibility from each non-network physician or provider providing the service.

SECTION 1.05. Section 1301.0053, Insurance Code, is amended to read as follows:

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. (a) If an out-of-network [~~a nonpreferred~~] provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall reimburse the out-of-network [~~nonpreferred~~] provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network [~~nonpreferred~~] provider for the provision of the services and any supply related to those services.

(b) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the insured's exclusive provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) a modified amount as determined under the insurer's internal dispute resolution process; and

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

SECTION 1.06. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.010 to read as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this subsection in an explanation of benefits provided to the insured and the physician or health care provider in connection with a health care service or supply that is subject to Section 1301.0053, 1301.155, 1301.164, or 1301.165. The notice must include:

(1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;

(2) the amount the physician or provider may bill the insured under the insured's preferred provider benefit plan; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of the out-of-network claim dispute resolution process under Chapter 1467.

(b) A physician or health care provider that provides a service or supply described by Subsection (a) shall provide notice of the prohibitions described by Subsection (a)(1) in an invoice for the service or supply provided to an insured.

SECTION 1.07. Section 1301.155, Insurance Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate and at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; [~~and~~]

(3) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition; and

(4) supplies related to a service described by this subsection.

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

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) a modified amount as determined under the insurer's internal dispute resolution process; and

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

SECTION 1.08. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Sections 1301.164 and 1301.165 to read as follows:

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), an insurer shall pay for a health care service performed for or a supply related to that service provided to an insured by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a preferred provider.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a

claim as an agent or assignee of the provider may not bill an insured receiving a health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) a modified amount as determined under the insurer's internal dispute resolution process; and

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

(d) This section does not apply to a nonemergency health care service that an insured elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the insured's potential financial responsibility from each out-of-network provider providing the service.

Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), an insurer shall pay for a medical care or health care service performed by or a supply related to that service provided by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a medical care or health care service performed by a preferred provider.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount

greater than an applicable copayment, coinsurance, or deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) the modified amount as determined under the insurer's internal dispute resolution process; and

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

(d) This section does not apply to a nonemergency health care service that an insured elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the insured's potential financial responsibility from each out-of-network provider providing the service.

SECTION 1.09. Section 1551.003, Insurance Code, is amended by adding Subdivision (15) to read as follows:

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

SECTION 1.10. Subchapter A, Chapter 1551, Insurance Code, is amended by adding Section 1551.015 to read as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group benefits program shall provide written notice in accordance with this subsection in an explanation of benefits provided to the participant and the physician or health care provider in connection with a health care service or supply that is subject to Section 1551.228, 1551.229, or 1551.230. The notice must include:

(1) a statement of the billing prohibition under Section 1551.228, 1551.229, or 1551.230, as applicable;

(2) the amount the physician or provider may bill the participant under the participant's managed care plan; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of the

out-of-network claim dispute resolution process under Chapter 1467.

(b) A physician or health care provider that provides a service or supply described by Subsection (a) shall provide notice of the prohibitions described by Subsection (a)(1) in an invoice for the service or supply provided to a participant.

SECTION 1.11. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Sections 1551.228, 1551.229, and 1551.230 to read as follows:

Sec. 1551.228. EMERGENCY CARE COVERAGE. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) A managed care plan provided under the group benefits program must provide out-of-network emergency care coverage for participants in accordance with this section.

(c) The coverage must require the administrator of the plan to pay for emergency care performed by or a supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate.

(d) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the participant's managed care plan that:

(1) is based on:

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

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

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

Sec. 1551.229. OUT-OF-NETWORK FACILITY-BASED PROVIDER COVERAGE. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care services to patients of a health care facility.

(b) A managed care plan provided under the group benefits program must provide out-of-network facility-based provider coverage for participants in accordance with this section.

(c) Except as provided by Subsection (e), the coverage must require the administrator of the plan to pay for a health care service performed for or a supply related to that service provided to a participant by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(d) Except as provided by Subsection (e), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care service or supply described by Subsection (c) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the participant's managed care plan that:

(1) is based on:

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

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

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

(e) This section does not apply to a nonemergency health care service that a participant elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the participant's potential financial responsibility from each out-of-network provider providing the service.

Sec. 1551.230. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) A managed care plan provided under the group benefits

program must provide out-of-network diagnostic imaging provider and laboratory service provider coverage for participants in accordance with this section.

(c) Except as provided by Subsection (e), the coverage must require the administrator of the plan to pay for a health care service performed for or a supply related to that service provided to a participant by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a participating provider.

(d) Except as provided by Subsection (e), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care service or supply described by Subsection (c) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the participant's managed care plan that:

(1) is based on:

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

(B) the modified amount as determined under the administrator's internal dispute resolution process; and

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

(e) This section does not apply to a nonemergency health care service that a participant elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the participant's potential financial responsibility from each out-of-network provider providing the service.

SECTION 1.12. Section 1575.002, Insurance Code, is amended by adding Subdivision (8) to read as follows:

(8) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan

document or policy.

SECTION 1.13. Subchapter A, Chapter 1575, Insurance Code, is amended by adding Section 1575.009 to read as follows:

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group program shall provide written notice in accordance with this subsection in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care service or supply that is subject to Section 1575.171, 1575.172, or 1575.173. The notice must include:

(1) a statement of the billing prohibition under Section 1575.171, 1575.172, or 1575.173, as applicable;

(2) the amount the physician or provider may bill the enrollee under the enrollee's managed care plan; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of the out-of-network claim dispute resolution process under Chapter 1467.

(b) A physician or health care provider that provides a service or supply described by Subsection (a) shall provide notice of the prohibitions described by Subsection (a)(1) in an invoice for the service or supply provided to an enrollee.

SECTION 1.14. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Sections 1575.171, 1575.172, and 1575.173 to read as follows:

Sec. 1575.171. EMERGENCY CARE COVERAGE. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) A managed care plan provided under the group program must provide out-of-network emergency care coverage in accordance with this section.

(c) The coverage must require the administrator of the plan to pay for emergency care performed by or a supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate.

(d) For emergency care subject to this section or a supply

related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the enrollee's managed care plan that:

(1) is based on:

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

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

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

Sec. 1575.172. OUT-OF-NETWORK FACILITY-BASED PROVIDER COVERAGE. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care services to patients of a health care facility.

(b) A managed care plan provided under the group program must provide out-of-network facility-based provider coverage for enrollees in accordance with this section.

(c) Except as provided by Subsection (e), the coverage must require the administrator of the plan to pay for a health care service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

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

(1) is based on:

(A) the amount initially determined payable by

the administrator; or

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

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

(e) This section does not apply to a nonemergency health care service that an enrollee elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the enrollee's potential financial responsibility from each out-of-network provider providing the service.

Sec. 1575.173. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) A managed care plan provided under the group program must provide out-of-network diagnostic imaging provider and laboratory service provider coverage for enrollees in accordance with this section.

(c) Except as provided by Subsection (e), the coverage must require the administrator of the plan to pay for a health care service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a participating provider.

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

(1) is based on:

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

(B) the modified amount as determined under the administrator's internal dispute resolution process; and

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

(e) This section does not apply to a nonemergency health care service that an enrollee elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the enrollee's potential financial responsibility from each out-of-network provider providing the service.

SECTION 1.15. Subchapter A, Chapter 1579, Insurance Code, is amended by adding Section 1579.009 to read as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this subsection in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care service or supply that is subject to Section 1579.109, 1579.110, or 1579.111. The notice must include:

(1) a statement of the billing prohibition under Section 1579.109, 1579.110, or 1579.111, as applicable;

(2) the amount the physician or provider may bill the enrollee under the enrollee's managed care plan; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of the out-of-network claim dispute resolution process under Chapter 1467.

(b) A physician or health care provider that provides a service or supply described by Subsection (a) shall provide notice of the prohibitions described by Subsection (a)(1) in an invoice for the service or supply provided to an enrollee.

SECTION 1.16. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Sections 1579.109, 1579.110, and 1579.111 to

read as follows:

Sec. 1579.109. EMERGENCY CARE COVERAGE. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) A managed care plan provided under this chapter must provide out-of-network emergency care coverage in accordance with this section.

(c) The coverage must require the administrator of the plan to pay for emergency care performed by or a supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate.

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

(1) is based on:

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

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

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

Sec. 1579.110. OUT-OF-NETWORK FACILITY-BASED PROVIDER COVERAGE. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care services to patients of a health care facility.

(b) A managed care plan provided under this chapter must provide out-of-network facility-based provider coverage to enrollees in accordance with this section.

(c) Except as provided by Subsection (e), the coverage must require the administrator of the plan to pay for a health care service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an

agreed rate if the provider performed the service at a health care facility that is a participating provider.

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

(1) is based on:

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

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

(2) does not include any additional amount determined to be owed to the provider under Chapter 1467.

(e) This section does not apply to a nonemergency health care service that an enrollee elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the enrollee's potential financial responsibility from each out-of-network provider providing the service.

Sec. 1579.111. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) A managed care plan provided under this chapter must provide out-of-network diagnostic imaging provider and laboratory service provider coverage for enrollees in accordance with this section.

(c) Except as provided by Subsection (e), the coverage must require the administrator of the plan to pay for a health care service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and

customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a participating provider.

(d) Except as provided by Subsection (e), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim through the provider may not bill an enrollee receiving a health care service or supply described by Subsection (c) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the enrollee's managed care plan that:

(1) is based on:

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

(B) a modified amount as determined under the administrator's internal dispute resolution process; and

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

(e) This section does not apply to a nonemergency health care service that an enrollee elects to receive:

(1) in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) with notice of the enrollee's potential financial responsibility from each out-of-network provider providing the service.

ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SECTION 2.01. Section 1467.001, Insurance Code, is amended by adding Subdivisions (1-a), (2-c), (2-d), (4-b), and (6-a) and amending Subdivisions (2-a), (2-b), (3), and (7) to read as follows:

(1-a) "Arbitration" means a process in which an impartial arbiter issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim.

(2-a) "Diagnostic imaging provider" means a health care provider who performs a diagnostic imaging service on a

patient for a fee or interprets imaging produced by a diagnostic imaging service.

(2-b) "Diagnostic imaging service" means magnetic resonance imaging, computed tomography, positron emission tomography, or any hybrid technology that combines any of those imaging modalities.

(2-c) "Emergency care" has the meaning assigned by Section 1301.155.

(2-d) [~~(2-b)~~] "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.

(3) "Enrollee" means an individual who is eligible to receive benefits through a [~~preferred provider benefit plan or a~~] health benefit plan subject to this chapter [~~under Chapter 1551, 1575, or 1579~~].

(4-b) "Laboratory service provider" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a person who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

(6-a) "Out-of-network provider" means a diagnostic imaging provider, emergency care provider, facility-based provider, or laboratory service provider that is not a participating provider for a health benefit plan.

(7) "Party" means a health benefit plan issuer [~~an insurer~~] offering a health [~~a preferred provider~~] benefit plan, an administrator, or an out-of-network [~~a facility-based provider or emergency care~~] provider or the provider's representative who participates in an arbitration [~~a mediation~~] conducted under this chapter. [~~The enrollee is also considered a party to the mediation.~~]

SECTION 2.02. Sections 1467.002, 1467.003, and 1467.005, Insurance Code, are amended to read as follows:

Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter applies to:

(1) a health benefit plan offered by a health

maintenance organization operating under Chapter 843;

(2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and

(3) [~~(2)~~] an administrator of a managed care [~~health benefit~~] plan[~~, other than a health maintenance organization plan,~~] under Chapter 1551, 1575, or 1579.

Sec. 1467.003. RULES. (a) The commissioner, the Texas Medical Board, and any other appropriate regulatory agency[~~, and the chief administrative law judge~~] shall adopt rules as necessary to implement their respective powers and duties under this chapter.

(b) Section 2001.0045, Government Code, does not apply to a rule adopted under this chapter.

Sec. 1467.005. REFORM. This chapter may not be construed to prohibit:

(1) a health [~~an insurer offering a preferred provider~~] benefit plan issuer or administrator from, at any time, offering a reformed claim settlement; or

(2) an out-of-network [~~a facility-based provider or emergency care~~] provider from, at any time, offering a reformed charge for health care or medical services or supplies.

SECTION 2.03. Subchapter A, Chapter 1467, Insurance Code, is amended by adding Section 1467.006 to read as follows:

Sec. 1467.006. BENCHMARKING DATABASE. (a) The commissioner shall select an organization to maintain a benchmarking database that contains information necessary to calculate, with respect to a health care or medical service or supply, for each geographical area in this state:

(1) the 80th percentile of billed amounts of all physicians or health care providers; and

(2) the 50th percentile of rates paid to participating providers.

(b) The commissioner may not select under Subsection (a) an organization that is financially affiliated with a health benefit plan issuer.

SECTION 2.04. The heading to Subchapter B, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER B. MANDATORY BINDING ARBITRATION [~~MEDIATION~~]

SECTION 2.05. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Sections 1467.050 and 1467.0505 to read as follows:

Sec. 1467.050. ESTABLISHMENT AND ADMINISTRATION OF ARBITRATION PROGRAM. (a) The commissioner shall establish and administer an arbitration program to resolve disputes over out-of-network provider amounts in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on the department's Internet website through which a request for arbitration under Section 1467.051 may be submitted; and

(2) shall maintain a list of qualified arbitrators for the program.

Sec. 1467.0505. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) The only issue that an arbitrator may determine under this subchapter is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider.

(b) The determination must, at a minimum, take into account:

(1) whether there is a gross disparity between the fee billed by the out-of-network provider and:

(A) fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and

(B) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;

(2) the level of training, education, and experience of the out-of-network provider;

(3) the out-of-network provider's usual billed amount for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;

(4) the circumstances and complexity of the enrollee's

particular case, including the time and place of the provision of the service or supply;

(5) individual enrollee characteristics;

(6) the 80th percentile of all billed amounts for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database described by Section 1467.006; and

(7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database described by Section 1467.006.

SECTION 2.06. The heading to Section 1467.051, Insurance Code, is amended to read as follows:

Sec. 1467.051. AVAILABILITY OF MANDATORY ARBITRATION [~~MEDIATION; EXCEPTION~~].

SECTION 2.07. Section 1467.051, Insurance Code, is amended by amending Subsections (a) and (b) and adding Subsections (a-1), (e), (f), and (g) to read as follows:

(a) An out-of-network provider, health benefit plan issuer, or administrator [~~An enrollee~~] may request arbitration [~~mediation~~] of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:

(1) there is an [~~the~~] amount billed by the provider and unpaid by the issuer or administrator [~~for which the enrollee is responsible to a facility-based provider or emergency care provider,~~] after copayments, deductibles, and coinsurance for which an enrollee may not be billed [~~, including the amount unpaid by the administrator or insurer, is greater than $500~~]; and

(2) the health benefit claim is for:

(A) emergency care; [~~or~~]

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating [~~preferred~~] provider or that has a contract with the administrator;

(C) an out-of-network laboratory service; or

(D) an out-of-network diagnostic imaging

service.

(a-1) If the issuer or administrator offers a process for an out-of-network provider to appeal a claim, the arbitration may not be requested before the earlier of:

(1) the completion of the appeal; or

(2) the 45th day after the date the provider initiated the appeal.

(b) If a person [~~Except as provided by Subsections (c) and (d), if an enrollee~~] requests arbitration [~~mediation~~] under this subchapter, the out-of-network [~~facility-based~~] provider [~~or emergency care provider,~~] or the provider's representative, and the health benefit plan issuer [~~insurer~~] or the administrator, as appropriate, shall participate in the arbitration [~~mediation~~].

(e) The person who requests the arbitration shall provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to:

(1) the department; and

(2) each other party.

(f) In an effort to settle the claim before arbitration, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which the arbitration is requested. A health benefit plan issuer or administrator shall make a reasonable effort to arrange the teleconference.

(g) The parties may agree to submit multiple claims to arbitration in one proceeding.

SECTION 2.08. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Section 1467.0515 to read as follows:

Sec. 1467.0515. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Notwithstanding Section 1467.004, an out-of-network provider, health benefit plan issuer, or administrator may not file suit for an out-of-network claim subject to this chapter until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

(b) An arbitration conducted under this subchapter is not subject to Title 7, Civil Practice and Remedies Code.

SECTION 2.09. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Sections 1467.0535, 1467.0545, 1467.0555, and

1467.0565 to read as follows:

Sec. 1467.0535. SELECTION AND APPROVAL OF ARBITRATOR. (a) If the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is requested, the party requesting the arbitration shall notify the commissioner, and the commissioner shall select an arbitrator from the commissioner's list of approved arbitrators.

(b) In approving an individual as an arbitrator, the commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an arbitration. A conflict of interest includes current or recent ownership or employment of the individual or a close family member in a health benefit plan issuer or out-of-network provider that may be involved in the arbitration.

(c) The commissioner shall immediately terminate the approval of an arbitrator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as an arbitrator.

Sec. 1467.0545. PROCEDURES. (a) The arbitrator shall set a date for submission of all information to be considered by the arbitrator.

(b) A party may not engage in discovery in connection with the arbitration.

(c) On agreement of all parties, any deadline under this subchapter may be extended.

(d) Unless otherwise agreed to by the parties, an arbitrator:

(1) may not consider medical records that were not presented to the health benefit plan issuer or administrator during an appeals process described by Section 1467.051(a-1);

(2) may not review a claim arising from an adverse determination by a utilization review agent under Chapter 4201 that may be reviewed by an independent review organization; and

(3) may not determine whether a health benefit plan covers a particular health care or medical service or supply.

(e) The parties shall evenly split and pay the arbitrator's

fees and expenses.

Sec. 1467.0555. DECISION. (a) Not later than the 75th day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed amount or the initial payment made by the health benefit plan issuer or administrator is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.0505(b), provided that:

(A) the provider may revise the billed amount to correct a billing error before the completion of an appeal process described by Section 1467.051(a-1); and

(B) the health benefit plan issuer or administrator may increase the initial payment under the appeal process described by Section 1467.051(a-1); and

(2) selects the amount described by Subdivision (1) as the binding award amount.

(b) An arbitrator may not modify the binding award amount selected under Subsection (a).

Sec. 1467.0565. EFFECT OF DECISION. (a) An arbitrator's decision under Section 1467.0555 is binding.

(b) Not later than the 90th day after the date of an arbitrator's decision under Section 1467.0555, a party not satisfied with the decision may file an action to determine the payment due to an out-of-network provider.

(c) In an action filed under Subsection (b), the court shall determine whether the arbitrator's decision is proper based on a substantial evidence standard of review.

(d) A health benefit plan issuer or administrator shall pay to an out-of-network provider any additional amount necessary to satisfy a binding award or a court's determination in an action filed under Subsection (b), as applicable.

SECTION 2.10. Subchapter C, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER C. BAD FAITH PARTICIPATION [~~MEDIATION~~]

Sec. 1467.101. BAD FAITH. [~~(a)~~] The following conduct

constitutes bad faith participation [~~mediation~~] for purposes of this chapter:

(1) failing to participate in the informal settlement teleconference under Section 1467.051(f) or arbitration under Subchapter B [~~mediation~~];

(2) failing to provide information the arbitrator [~~mediator~~] believes is necessary to facilitate a decision [~~an agreement~~]; [~~or~~]

(3) failing to designate a representative participating in the arbitration [~~mediation~~] with full authority to enter into any [~~mediated~~] agreement; or

(4) failing to participate in the arbitration.

[~~(b) Failure to reach an agreement is not conclusive proof of bad faith mediation.~~]

Sec. 1467.102. PENALTIES. [~~(a)~~] Bad faith participation or otherwise failing to comply with this chapter [~~mediation, by a party other than the enrollee,~~] is grounds for imposition of an administrative penalty by the regulatory agency that issued a license or certificate of authority to the party who committed the violation.

[~~(b) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith mediation, the regulatory agency that issued the license or certificate of authority shall impose an administrative penalty.~~]

SECTION 2.11. Sections 1467.151(a), (b), and (c), Insurance Code, are amended to read as follows:

(a) The commissioner and the Texas Medical Board or other regulatory agency, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. The rules adopted under this section must:

(1) distinguish among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed health care or medical care;

(2) develop a form for filing a complaint [~~and establish an outreach effort to inform enrollees of the availability of the claims dispute resolution process under this~~

~~chapter~~]; and

(3) ensure that a complaint is not dismissed without appropriate consideration[~~.~~

[~~(4) ensure that enrollees are informed of the availability of mandatory mediation; and~~

[~~(5) require the administrator to include a notice of the claims dispute resolution process available under this chapter with the explanation of benefits sent to an enrollee~~].

(b) The department and the Texas Medical Board or other appropriate regulatory agency shall maintain information[~~:~~

[~~(1)~~] on each complaint filed that concerns a claim or arbitration [~~mediation~~] subject to this chapter[~~; and~~

[~~(2) related to a claim that is the basis of an enrollee complaint~~], including:

(1) [~~(A)~~] the type of services or supplies that gave rise to the dispute;

(2) [~~(B)~~] the type and specialty, if any, of the out-of-network [~~facility-based~~] provider [~~or emergency care provider~~] who provided the out-of-network service or supply;

(3) [~~(C)~~] the county and metropolitan area in which the health care or medical service or supply was provided;

(4) [~~(D)~~] whether the health care or medical service or supply was for emergency care; and

(5) [~~(E)~~] any other information about:

(A) [~~(i)~~] the health benefit plan issuer [~~insurer~~] or administrator that the commissioner by rule requires; or

(B) [~~(ii)~~] the out-of-network [~~facility-based~~] provider [~~or emergency care provider~~] that the Texas Medical Board or other appropriate regulatory agency by rule requires.

(c) The information collected and maintained [~~by the department and the Texas Medical Board and other appropriate regulatory agencies~~] under Subsection (b) [~~(b)(2)~~] is public information as defined by Section 552.002, Government Code, and may not include personally identifiable information or health care or medical information.

ARTICLE 3. CONFORMING AMENDMENTS

SECTION 3.01. Section 1456.001(6), Insurance Code, is amended to read as follows:

(6) "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. [~~The term includes a network operated by:~~

[~~(A) a health maintenance organization;~~

[~~(B) a preferred provider benefit plan issuer; or~~

[~~(C) another entity that issues a health benefit plan, including an insurance company.~~]

SECTION 3.02. Sections 1456.002(a) and (c), Insurance Code, are amended to read as follows:

(a) This chapter applies to any health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) [~~a health maintenance organization operating under Chapter 843;~~

[~~(F)~~] a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(F) [~~(G)~~] an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(G) [~~(H)~~] an entity not authorized under this code or another insurance law of this state that contracts directly

for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(c) This chapter does not apply to:

(1) Medicaid managed care programs operated under Chapter 533, Government Code;

(2) Medicaid programs operated under Chapter 32, Human Resources Code; [~~or~~]

(3) the state child health plan operated under Chapter 62 or 63, Health and Safety Code; or

(4) a health benefit plan subject to Section 1271.157, 1301.164, 1551.229, 1575.172, or 1579.110.

SECTION 3.03. The following provisions of the Insurance Code are repealed:

(1) Section 1456.004(c);

(2) Sections 1467.001(2), (5), and (6);

(3) Sections 1467.051(c) and (d);

(4) Section 1467.0511;

(5) Section 1467.052;

(6) Section 1467.053;

(7) Section 1467.054;

(8) Section 1467.055;

(9) Section 1467.056;

(10) Section 1467.057;

(11) Section 1467.058;

(12) Section 1467.059;

(13) Section 1467.060; and

(14) Section 1467.151(d).

ARTICLE 4. STUDY

SECTION 4.01. Subchapter A, Chapter 38, Insurance Code, is amended by adding Section 38.004 to read as follows:

Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (a) The department shall, each biennium, conduct a study on the impacts of S.B. No. 1264, Acts of the 86th Legislature, Regular Session, 2019,

on Texas consumers and health coverage in this state, including:

(1) trends in billed amounts for health care or medical services or supplies, especially emergency services, laboratory services, diagnostic imaging services, and facility-based services;

(2) comparison of the total amount spent on out-of-network emergency services, laboratory services, diagnostic imaging services, and facility-based services by calendar year and provider type or physician specialty;

(3) trends and changes in network participation by providers of emergency services, laboratory services, diagnostic imaging services, and facility-based services by provider type or physician specialty, including whether any terminations were initiated by a health benefit plan issuer, administrator, or provider;

(4) the number of complaints, completed investigations, and disciplinary sanctions for billing by providers of emergency services, laboratory services, diagnostic imaging services, or facility-based services of insureds, enrollees, or plan participants for amounts greater than the insured's, enrollee's, or participant's responsibility under an applicable managed care plan, including an applicable copayment, coinsurance, or deductible;

(5) trends in amounts paid to out-of-network providers;

(6) trends in the usual and customary rate for health care or medical services or supplies, especially emergency services, laboratory services, diagnostic imaging services, and facility-based services; and

(7) the effectiveness of the claim dispute resolution process under Chapter 1467.

(b) In conducting the study described by Subsection (a), the department shall collect settlement data and verdicts or arbitration awards from parties to arbitration under Chapter 1467.

(c) The department:

(1) shall collect data quarterly from a health benefit plan issuer or administrator subject to Chapter 1467 to conduct the

study required by this section; and

(2) may utilize any reliable external resource or entity to acquire information reasonably necessary to prepare the report required by Subsection (d).

(d) Not later than December 1 of each even-numbered year, the department shall prepare and submit a written report on the results of the study under this section, including the department's findings, to the legislature.

ARTICLE 5. TRANSITION AND EFFECTIVE DATE

SECTION 5.01. The changes in law made by this Act apply only to a health care or medical service or supply provided on or after January 1, 2020. A health care or medical service or supply provided before January 1, 2020, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5.02. The Texas Department of Insurance, the Employees Retirement System of Texas, the Teacher Retirement System of Texas, and any other state agency subject to this Act are required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, those agencies may, but are not required to, implement a provision of this Act using other appropriations available for that purpose.

SECTION 5.03. This Act takes effect September 1, 2019.