

BILL ANALYSIS

Senate Research Center

S.B. 1264
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Business & Commerce
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1264 prevents consumers from receiving surprise medical bills so that in situations where the consumer has no choice over who provides their care, they cannot be surprise-billed. The bill prohibits all non-network facility-based providers at network hospitals and all non-network emergency care providers from sending surprise balance bills to consumers. The legislation requires health plans, including preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and health maintenance organizations (HMOs), to pay reasonable or agreed-upon amounts to out-of-network emergency care and facility-based providers. The bill also allows providers to dispute payment amounts through the existing Texas Department of Insurance mediation program. Consumers will still be responsible for their applicable co-pay, coinsurance, and deductible amounts.

S.B. 1264 will apply these surprise billing protections to more than 420,000 Texans enrolled in the Texas Employees Group Benefits plan (ERS), 250,000 Texans enrolled in the Teacher Retirement System (TRS-Care), and 430,000 enrolled in the self-funded TRS-ActiveCare program. Additionally, the legislation allows federally-regulated, self-funded health benefit plans (which make up at least 40 percent of the Texas health insurance market) to opt into the strong state protections afforded under the bill. If a consumer does receive a surprise balance bill, a consumer credit reporting agency is prohibited from reporting information on a medical collection from surprise balance bills. (Original Author's/Sponsor's Statement of Intent)

S.B. 1264 amends current law relating to consumer protections against certain medical and health care billing by certain out-of-network providers.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to certain regulatory agencies and the commissioner of insurance (commissioner) in SECTION 1.01 (Section 752.0003, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the commissioner in SECTION 2.03 (Section 1467.006, Insurance Code), SECTION 2.05 (Section 1467.0505, Insurance Code), SECTION 2.15 (Sections 1467.082 and 1467.084, Insurance Code) of this bill.

Rulemaking authority previously granted to the commissioner and the Texas Medical Board or other regulatory agency, as appropriate, is modified in in SECTION 2.17 (Section 1467.151, Insurance Code) of this bill.

Rulemaking authority previously granted to the commissioner is modified in SECTION 3.02 (Section 1456.006, Insurance Code) of this bill.

Rulemaking authority previously granted to the chief administrative law judge is rescinded in SECTION 2.02 (Section 1467.003, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

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

SECTION 1.01. Amends Subtitle G, Title 5, Insurance Code, by adding Chapter 752, as follows:

CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

Sec. 752.0001. DEFINITION. Defines "administrator" for purposes of this chapter.

Sec. 752.0002. INJUNCTION FOR BALANCE BILLING. (a) Authorizes the Texas attorney general (attorney general), if the attorney general receives a referral from the appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, 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, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition, to bring a civil action in the name of the state to enjoin the individual or entity from the violation.

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

Sec. 752.0003. ENFORCEMENT BY REGULATORY AGENCY. (a) Authorizes 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 to 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, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition.

(b) Authorizes the Texas Department of Insurance (TDI) to take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.

(c) Authorizes a regulatory agency described by Subsection (a) or the commissioner of insurance (commissioner) to adopt rules as necessary to implement this section. Provides that Section 2001.0045 (Requirement For Rule Increasing Costs to Regulated Persons), Government Code, does not apply to rules adopted under this subsection.

SECTION 1.02. Amends Subchapter A, Chapter 1271, Insurance Code, by adding Section 1271.008, as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) Requires a health maintenance organization to provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply provided by a non-network physician or provider. Requires the notice to include:

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

(2) the total amount the physician or provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; 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 mediation or arbitration, as applicable, under Chapter 1467 (Out-of-Network Claim Dispute Resolution).

(b) Requires a health maintenance organization to provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the health maintenance organization makes a payment under Section 1271.155, 1271.157, or 1271.158, as applicable.

SECTION 1.03. Amends Section 1271.155, Insurance Code, by amending Subsection (b) and adding Subsections (f), (g), and (h), as follows:

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

(1) makes no changes to this subdivision;

(2)–(3) makes nonsubstantive changes to these subdivisions; and

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

(f) Requires a health maintenance organization, for emergency care subject to this section or a supply related to that care, to make a payment required by Subsection (a) directly to the non-network physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 (Definition) for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(g) Prohibits a non-network physician or provider or a person asserting a claim as an agent or assignee of the physician or provider, for emergency care subject to this section or a supply related to that care, from billing an enrollee in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

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

(h) Prohibits this section from being construed to require the imposition of a penalty under Section 843.342 (Violation of Certain Claims Payment Provisions; Penalties).

SECTION 1.04. Amends Subchapter D, Chapter 1271, Insurance Code, by adding Sections 1271.157 and 1271.158, as follows:

Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS. (a) Defines "facility-based provider" for purposes of this section.

(b) Requires a health maintenance organization, except as provided by Subsection (d), to pay for a covered health care service performed for or a covered 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. Requires the health maintenance organization to make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(c) Prohibits a non-network facility-based provider or a person asserting a claim as an agent or assignee of the provider, except as provided by Subsection (d), from billing an enrollee receiving a health care service or supply described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

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

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

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

(e) Prohibits this section from being construed to require the imposition of a penalty under Section 843.342.

Sec. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) Defines "diagnostic imaging provider" and "laboratory service provider" for purposes of this section.

(b) Requires a health maintenance organization, except as provided by Subsection (d), to pay for a covered health care service performed by or a covered supply related to that service provided to an enrollee 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. Requires the health maintenance organization to make a payment required by this subsection directly to the physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim; or

(2) the 45th day after the date the health maintenance organization receives a nonelectronic clean claim as defined by Section 843.336 for those services that includes all information necessary for the health maintenance organization to pay the claim.

(c) Prohibits a non-network diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider, except as provided by Subsection (d), from billing an enrollee receiving a health care service or supply described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, a modified amount as determined under the health maintenance organization's internal appeal process; and

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

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

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

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

(e) Prohibits this section from being construed to require the imposition of a penalty under Section 843.342.

SECTION 1.05. Amends Section 1301.0045(b), Insurance Code, as follows:

(b) Prohibits this chapter (Preferred Provider Benefit Plans), except as provided by Sections 1301.0052 (Exclusive Provider Benefit Plans: Referrals For Medically Necessary Services), 1301.0053, 1301.155 (Emergency Care), 1301.164, and 1301.165, rather than except as provided by Sections 1301.0052 and 1301.155, from being construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

SECTION 1.06. Amends Section 1301.0053, Insurance Code, is amended to read as follows:

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE.

(a) Creates this subsection from existing text. Requires the issuer of an exclusive provider benefit plan, if an out-of-network provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, to reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services and any supply related to those services, rather than if a nonpreferred provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, to reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services. Requires the insurer to make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 (Definition) for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(b) Prohibits an out-of-network provider or a person asserting a claim as an agent or assignee of the provider, for emergency care subject to this section or a supply related to that care, from billing an insured in, and provides that the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, a modified amount as determined under the insurer's internal appeal process; and

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

(c) Prohibits this section from being construed to require the imposition of a penalty under Section 1301.137 (violation of Claims Payment Requirements; Penalty).

SECTION 1.07. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.010, as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) Requires an insurer to provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply provided by an out-of-network provider. Requires the notice to include:

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

(2) the total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; 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 mediation or arbitration, as applicable, under Chapter 1467.

(b) Requires an insurer to provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable.

SECTION 1.08. Amends Section 1301.155, Insurance Code, by amending Subsection (b) and adding Subsections (c), (d), and (e), as follows:

(b) Requires an insurer, if an insured cannot reasonably reach a preferred provider, to 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) makes no changes to this subdivision;

(2) and (3) makes nonsubstantive changes to these subdivisions; and

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

(c) Requires an insurer, for emergency care subject to this section or a supply related to that care, to make a payment required by this section directly to the out-of-network provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(d) Prohibits an out-of-network provider or a person asserting a claim as an agent or assignee of the provider, for emergency care subject to this section or a supply related to that care, from billing an insured in, and provides that the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, a modified amount as determined under the insurer's internal appeal process; and

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

(e) Prohibits this section from being construed to require the imposition of a penalty under Section 1301.137.

SECTION 1.09. Amends Subchapter D, Chapter 1301, Insurance Code, by adding Sections 1301.164 and 1301.165, as follows:

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS. (a) Defines "facility-based provider" for purposes of this section.

(b) Requires an insurer, except as provided by Subsection (d), to pay for a covered medical care or health care service performed for or a covered 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. Requires the insurer to make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(c) Prohibits 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, except as provided by Subsection (d), from billing an insured receiving a medical care or health care service or supply described by Subsection (b) in, and provides that the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, a modified amount as determined under the insurer's internal appeal process; and

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

(e) Prohibits this section from being construed to require the imposition of a penalty under Section 1301.137.

Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (a) Defines "diagnostic imaging provider" and "laboratory service provider" for purposes of this section.

(b) Requires an insurer, except as provided by Subsection (d), to pay for a covered medical care or health care service performed by or a covered supply related to that service provided to an insured 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. Requires the insurer to make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim.

(c) Prohibits 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, except as provided by Subsection (d), from billing an insured receiving a medical care or health care service or supply described by Subsection (b) in, and provides that the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and 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) if applicable, the modified amount as determined under the insurer's internal appeal process; and

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

(e) Prohibits this section from being construed to require the imposition of a penalty under Section 1301.137.

SECTION 1.10. Amends Section 1551.003, Insurance Code, by adding Subdivision (15) to define "usual and customary rate."

SECTION 1.11. Amends Subchapter A, Chapter 1551, Insurance Code, by adding Section 1551.015, as follows:

Sec. 1551.015. **BALANCE BILLING PROHIBITION NOTICE.** (a) Requires the administrator of a managed care plan provided under the Texas State Employees Group Benefits Program (group benefits program) to provide written notice in accordance with this section in an explanation of benefits provided to the participant and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. Requires the notice to include:

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

(2) the total amount the physician or provider may bill the participant under the participant's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; 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 mediation or arbitration, as applicable, under Chapter 1467.

(b) Requires the administrator to provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1551.228, 1551.229, or 1551.230, as applicable.

SECTION 1.12. Amends Subchapter E, Chapter 1551, Insurance Code, by adding Sections 1551.228, 1551.229, and 1551.230, as follows:

Sec. 1551.228. **EMERGENCY CARE PAYMENTS.** (a) Defines "emergency care" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under the group benefits program to pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

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

(1) is based on:

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

(B) if applicable, a modified amount as determined under the administrator's internal appeal 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 PAYMENTS.

(a) Defines "facility-based provider" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under the group benefits program, except as provided by Subsection (d), to pay for a covered health care or medical service performed for or a covered 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. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(c) Prohibits 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, except as provided by Subsection (d), from billing a participant receiving a health care or medical service or supply described by Subsection (b) in, and provides that the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that:

(1) is based on:

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

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

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the participant's managed care plan;

(B) discloses projected amounts for which the participant may be responsible; and

(C) discloses the circumstances under which the participant would be responsible for those amounts.

Sec. 1551.230. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) Defines "diagnostic imaging provider" and "laboratory service provider" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under the group benefits program, except as provided by Subsection (d), to pay for a covered health care or medical service performed for or a covered 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 or medical service performed by a participating provider. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(c) Prohibits 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, except as provided by Subsection (d), from billing a participant receiving a health care or medical service or supply described by Subsection (b) in, and provides that the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that:

(1) is based on:

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

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

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the participant's managed care plan;

(B) discloses projected amounts for which the participant may be responsible; and

(C) discloses the circumstances under which the participant would be responsible for those amounts.

SECTION 1.13. Amends Section 1575.002, Insurance Code, by adding Subdivision (8) to define "usual and customary rate."

SECTION 1.14. Amends Subchapter A, Chapter 1575, Insurance Code, by adding Section 1575.009, as follows:

Sec. 1575.009. **BALANCE BILLING PROHIBITION NOTICE.** (a) Requires the administrator of a managed care plan provided under the Texas Public School Employees Group Benefits Program (group program) to provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. Requires the notice to include:

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

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; 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 mediation or arbitration, as applicable, under Chapter 1467.

(b) Requires the administrator to provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1575.171, 1575.172, or 1575.173, as applicable.

SECTION 1.15. Amends Subchapter D, Chapter 1575, Insurance Code, by adding Sections 1575.171, 1575.172, and 1575.173, as follows:

Sec. 1575.171. **EMERGENCY CARE PAYMENTS.** (a) Defines "emergency care" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under the group program to pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

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

(1) is based on:

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

(B) if applicable, a modified amount as determined under the administrator's internal appeal 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 PAYMENTS.

(a) Defines "facility-based provider" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under the group program, except as provided by Subsection (d), to pay for a covered health care or medical service performed for or a covered 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. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(c) Prohibits 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, except as provided by Subsection (d), from billing an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

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

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

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

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

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

Sec. 1575.173. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) Defines "diagnostic imaging provider" and "laboratory service provider" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under the group program, except as provided by Subsection (d), to pay for a covered health care or medical service performed for or a covered 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 or medical service performed by a participating provider. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(c) Prohibits 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, except as provided by Subsection (d), from billing an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

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

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

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

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

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

SECTION 1.16. Amends Section 1579.002, Insurance Code, by adding Subdivision (8) to define "usual and customary rate."

SECTION 1.17. Amends Subchapter A, Chapter 1579, Insurance Code, by adding Section 1579.009, as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) Requires the administrator of a managed care plan provided under this chapter (Texas School Employees Uniform Group Health Coverage) to provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. Requires the notice to include:

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

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; 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 mediation or arbitration, as applicable, under Chapter 1467.

(b) Requires the administrator to provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, or 1579.111, as applicable.

SECTION 1.18. Amends Subchapter C, Chapter 1579, Insurance Code, by adding Sections 1579.109, 1579.110, and 1579.111, as follows:

Sec. 1579.109. EMERGENCY CARE PAYMENTS. (a) Defines "emergency care" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under this chapter to pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

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

(1) is based on:

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

(B) if applicable, a modified amount as determined under the administrator's internal appeal 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 PAYMENTS.

(a) Defines "facility-based provider" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under this chapter, except as provided by Subsection (d), to pay for a covered health care or medical service performed for or a covered 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. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(c) Prohibits 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, except as provided by Subsection (d), from billing an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

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

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

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

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

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

Sec. 1579.111. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) Defines "diagnostic imaging provider" and "laboratory service provider" for purposes of this section.

(b) Requires the administrator of a managed care plan provided under this chapter, except as provided by Subsection (d), to pay for a covered health care or medical service performed for or a covered 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 or medical service performed by a participating provider. Requires the administrator to make a payment required by this subsection directly to the provider not later than, as applicable:

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

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

(c) Prohibits 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, except as provided by Subsection (d), from billing an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

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

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

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

(d) Provides that this section does not apply to a nonemergency health care or medical service:

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

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

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

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

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

ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SECTION 2.01. Amends Section 1467.001, Insurance Code, by adding Subdivisions (1-a), (2-c), (2-d), (4-b), and (6-a) and amending Subdivisions (2-a), (2-b), (3), (5), and (7) to define "arbitration," "diagnostic imaging provider," "diagnostic imaging service," "laboratory service provider," "out-of-network provider," "emergency care," and "emergency care provider," and to redefine "enrollee," "mediation," and "party."

SECTION 2.02. Amends Sections 1467.002, 1467.003, and 1467.005, Insurance Code, as follows:

Sec. 1467.002. **APPLICABILITY OF CHAPTER.** Creates Subdivisions (2) and (3) from existing text. Provides that this chapter applies to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations);

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

(3) makes no further changes to this subdivision.

Sec. 1467.003. **RULES.** (a) Creates this subsection from existing text. Requires the commissioner, the Texas Medical Board (TMB), and any other appropriate regulatory agency, rather than requiring the commissioner, TMB, any other appropriate regulatory agency, and the chief administrative law judge, to adopt rules as necessary to implement their respective powers and duties under this chapter.

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

Sec. 1467.005. **REFORM.** Provides that this chapter may not be construed to prohibit:

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

(2) an out-of-network provider from, at any time, offering a reformed charge for health care or medical services or supplies, rather than 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. Amends Subchapter A, Chapter 1467, Insurance Code, by adding Section 1467.006, as follows:

Sec. 1467.006. BENCHMARKING DATABASE. (a) Defines "geozip area" for purposes of this section.

(b) Requires the commissioner to select an organization to maintain a benchmarking database in accordance with this section. Prohibits the organization from:

(1) being affiliated with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider; or

(2) having any other conflict of interest.

(c) Requires the benchmarking database to contain information necessary to calculate, with respect to a health care or medical service or supply, for each geozip area in this state:

(1) the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and

(2) the 50th percentile of rates paid to participating providers who are not facilities.

(d) Authorizes the commissioner to adopt rules governing the submission of information for the benchmarking database described by Subsection (c).

SECTION 2.04. Amends the heading to Subchapter B, Chapter 1467, Insurance Code, to read as follows:

SUBCHAPTER B. MANDATORY MEDIATION FOR OUT-OF-NETWORK FACILITIES

SECTION 2.05. Amends Subchapter B, Chapter 1467, Insurance Code, by adding Sections 1467.050 and 1467.0505, as follows:

Sec. 1467.050. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider that is a facility.

(b) Provides that this subchapter does not apply to a health benefit claim for the professional or technical component of a physician service.

Sec. 1467.0505. ESTABLISHMENT AND ADMINISTRATION OF MEDIATION PROGRAM. (a) Requires the commissioner to establish and administer a mediation program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) Requires the commissioner:

(1) to adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program, including the establishment of a portal on the Texas Department of Insurance's (TDI) Internet website through which a request for mediation under Section 1467.051 may be submitted; and

(2) to maintain a list of qualified mediators for the program.

SECTION 2.06. Amends the heading to Section 1467.051, Insurance Code, to read as follows:

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION.

SECTION 2.07. Amends Sections 1467.051(a) and (b), Insurance Code, as follows:

(a) Authorizes an out-of-network provider or a health benefit plan issuer or administrator, rather than authorizing an enrollee, to request mediation of a settlement of an out-of-network health benefit claim through a portal on TDI's Internet website if:

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

(2) the health benefit claim is for:

(A) makes a nonsubstantive change to this paragraph;

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

(C) an out-of-network diagnostic imaging service, rather than a health care or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator.

(b) Requires the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, if a person requests mediation under this subchapter, to participate in the mediation, rather than requiring the facility-based provider or emergency care provider, or the provider's representative, and the insurer or the administrator, as appropriate, if an enrollee requests mediation under this subchapter (Mandatory Mediation), except as provided by Subsections (c) and (d), to participate in the mediation.

SECTION 2.08. Amends Section 1467.052, Insurance Code, by amending Subsections (a) and (c) and adding Subsection (d), as follows:

(a) Requires a person, except as provided by Subsection (b), to qualify for an appointment as a mediator under this subchapter, rather than under this chapter, to have completed at least 40 classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the commissioner, rather than approved by the chief administrative law judge.

(c) Prohibits a person from acting as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with a health benefit plan issuer or administrator, rather than an insurer offering the preferred provider benefit plan, or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.

(d) Requires the commissioner to immediately terminate the approval of a mediator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as a mediator.

SECTION 2.09. Amends Section 1467.053, Insurance Code, by adding Subsection (b-1) and amending Subsection (d), as follows:

(b-1) Requires the party requesting the mediation, if the parties do not select a mediator by mutual agreement on or before the 30th day after the date the mediation is requested, to notify the commissioner, and requires the commissioner to select a mediator from the commissioner's list of approved mediators.

(d) Requires the mediator's fees to be split evenly and paid by the health benefit plan issuer or administrator and the out-of-network provider, rather than by the insurer or administrator and the facility-based provider or emergency care provider.

SECTION 2.10. Amends Section 1467.054, Insurance Code, by amending Subsections (a) and (d) and adding Subsection (b-1), as follows:

(a) Authorizes an out-of-network provider or a health benefit plan issuer or administrator, rather than an enrollee, to request mandatory mediation under this subchapter, rather than under this chapter.

(b-1) Requires the person who requests the mediation to provide written notice on the date the mediation is requested in the form and manner provided by commissioner rule to:

(1) TDI; and

(2) each other party.

(d) Makes conforming changes to this subsection.

SECTION 2.11. Amends Section 1467.055, Insurance Code, by adding Subsections (c-1) and (k) and amending Subsections (g) and (i), as follows:

(c-1) Provides that information submitted by the parties to the mediator is confidential and not subject to disclosure under Chapter 552 (Public Information), Government Code.

(g) Requires a mediation to be held not later than the 180th day after the date of the request for mediation, rather than requiring a mediation, except at the request of an enrollee, to be held not later than the 180th day after the date of the request for mediation.

(i) Prohibits a health care or medical service or supply provided by an out-of-network provider, rather than provided by a facility-based provider or emergency care provider, from being summarily disallowed. Provides that this subsection does not require a health benefit plan issuer or administrator, rather than an insurer or administrator, to pay for an uncovered service or supply.

(k) Authorizes any deadline under this subchapter, on agreement of all parties, to be extended.

SECTION 2.12. Amends Sections 1467.056(a), (b), and (d), Insurance Code, as follows:

(a) Creates Subdivisions (1) and (2) from existing Subdivisions (1)(A) and (B). Deletes existing Subdivision (2) and text relating to determining, as a result of the amounts described by Subdivision (1), the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is responsible to the facility-based provider or emergency care provider. Makes nonsubstantive changes throughout this subsection.

Requires the parties, in a mediation under this subchapter, rather than chapter, to evaluate whether:

(1) the amount charged by the out-of-network provider, rather than charged by the facility-based provider or emergency care provider, for the health care or medical service or supply is excessive; and

(2) the amount paid by the health benefit plan issuer or administrator, rather than the amount paid by the insurer or administrator, represents the usual and customary rate for the health care or medical service or supply or is unreasonably low.

(b) Authorizes the out-of-network provider, rather than the facility-based provider or emergency care provider, to present information regarding the amount charged for the health care or medical service or supply. Authorizes the health benefit plan issuer or administrator to present information regarding the amount paid by the issuer or administrator, rather than authorizing the insurer or administrator to present information regarding the amount paid by the insurer or administrator.

(d) Provides that the goal of the mediation is to reach an agreement between the out-of-network provider and the health benefit plan issuer or administrator, as applicable, as to the amount paid by the issuer or administrator to the out-of-network provider and the amount charged by the out-of-network provider, rather than to reach an agreement among the enrollee, the facility-based provider or emergency care provider, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based provider or emergency care provider, the amount charged by the facility-based provider or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee.

SECTION 2.13. Amends Subchapter B, Chapter 1467, Insurance Code, by adding Section 1467.0575, as follows:

Sec. 1467.0575. RIGHT TO FILE ACTION. Authorizes either party to a mediation for which there was no agreement, not later than the 45th day after the date that the mediator's report is provided to TDI under Section 1467.060, to file a civil action to determine the amount due to an out-of-network provider. Prohibits a party from bringing a civil action before the conclusion of the mediation process under this subchapter.

SECTION 2.14. Amends Section 1467.060, Insurance Code, as follows:

Sec. 1467.060. REPORT OF MEDIATOR. Requires the mediator, not later than the 45th day after the date the mediation concludes, to report to the commissioner and TMB or the other appropriate regulatory agency:

(1) makes no changes to this subdivision; and

(2) whether the parties reached an agreement, rather than whether the parties reached an agreement or the mediator made a referral under Section 1467.057 (No Agreed Resolution).

SECTION 2.15. Amends Chapter 1467, Insurance Code, by adding Subchapter B-1, as follows:

SUBCHAPTER B-1. MANDATORY BINDING ARBITRATION FOR OTHER PROVIDERS

Sec. 1467.081. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider who is not a facility.

Sec. 1467.082. ESTABLISHMENT AND ADMINISTRATION OF ARBITRATION PROGRAM. (a) Requires the commissioner to establish and administer an arbitration program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) Requires the commissioner to adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on TDI's Internet website through which a request for arbitration under Section 1467.084 may be submitted, and to maintain a list of qualified arbitrators for the program.

Sec. 1467.083. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) Provides that 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) Requires the determination to 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 charge 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 charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(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 geozip area as reported in a benchmarking database described by Section 1467.006;

(8) the history of network contracting between the parties;

(9) historical data for the percentiles described by Subdivisions (6) and (7); and

(10) an offer made during the informal settlement teleconference required under Section 1467.084(d).

Sec. 1467.084. AVAILABILITY OF MANDATORY ARBITRATION. (a) Authorizes an out-of-network provider or the health benefit plan issuer or administrator, not later than the 90th day after the date the out-of-network provider receives the initial payment for a health care or medical service or supply, to request arbitration of a settlement of an out-of-network health benefit claim through a portal on TDI's Internet website if:

(1) there is a charge billed by the provider and unpaid by the issuer or administrator after copayments, coinsurance, and deductibles for which an enrollee may not be billed; and

(2) the health benefit claim is for:

(A) emergency care;

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider;

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

(D) an out-of-network diagnostic imaging service.

(b) Requires the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, if a person requests arbitration under this subchapter, to participate in the arbitration.

(c) Requires the person who requests the arbitration to provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to TDI and each other party.

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

(e) Requires the commissioner to adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding. Requires the rules to provide that the total amount in controversy for multiple claims in one proceeding may not exceed \$5,000 and that the multiple claims in one proceeding must be limited to the same out-of-network provider.

Sec. 1467.085. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Prohibits an out-of-network provider or health benefit plan issuer or administrator, notwithstanding Section 1467.004 (Remedies Not Exclusive), from filing 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) Provides that an arbitration conducted under this subchapter is not subject to Title 7 (Alternate Methods of Dispute Resolution), Civil Practice and Remedies Code.

Sec. 1467.086. SELECTION AND APPROVAL OF ARBITRATOR. (a) Requires the party requesting the arbitration, if the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is requested, to notify the commissioner, and requires the commissioner to select an arbitrator from the commissioner's list of approved arbitrators.

(b) Requires the commissioner, in selecting an arbitrator under this section, to give preference to an arbitrator who is knowledgeable and experienced in

applicable principles of contract and insurance law and the health care industry generally.

(c) Requires the commissioner, in approving an individual as an arbitrator, to 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. Provides that a conflict of interest includes current or recent ownership or employment of the individual or a close family member in any health benefit plan issuer or administrator or physician, health care practitioner, or other health care provider.

(d) Requires the commissioner to 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. 1467.087. PROCEDURES. (a) Requires the arbitrator to set a date for submission of all information to be considered by the arbitrator.

(b) Prohibits a party from engaging in discovery in connection with the arbitration.

(c) Authorizes any deadline under this subchapter, on agreement of all parties, to be extended.

(d) Prohibits an arbitrator, unless otherwise agreed to by the parties, from determining whether a health benefit plan covers a particular health care or medical service or supply.

(e) Requires the parties to evenly split and pay the arbitrator's fees and expenses.

(f) Provides that information submitted by the parties to the arbitrator is confidential and not subject to disclosure under Chapter 552, Government Code.

Sec. 1467.088. DECISION. (a) Requires an arbitrator, not later than the 51st day after the date the arbitration is requested, to provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed charge or the payment made by the health benefit plan issuer or administrator, as those amounts were last modified during the issuer's or administrator's internal appeal process, if the provider elects to participate, or the informal settlement teleconference required by Section 1467.084(d), as applicable, is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.083(b); and

(2) selects the amount determined to be closest under Subdivision (1) as the binding award amount.

(b) Prohibits an arbitrator from modifying the binding award amount selected under Subsection (a).

(c) Requires an arbitrator to provide written notice in the form and manner prescribed by commissioner rule of the reasonable amount for the services or supplies and the binding award amount. Requires the parties, if the parties settle before a decision, to provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement. Requires TDI to maintain a record of notices provided under this subsection.

Sec. 1467.089. EFFECT OF DECISION. (a) Provides that an arbitrator's decision under Section 1467.088 is binding.

(b) Authorizes a party not satisfied with the decision, not later than the 45th day after the date of an arbitrator's decision under Section 1467.088, to file an action to determine the payment due to an out-of-network provider.

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

(d) Requires a health benefit plan issuer or administrator, not later than the 30th day after the date of an arbitrator's decision under Section 1467.088, to pay to an out-of-network provider any additional amount necessary to satisfy the binding award.

SECTION 2.16. Amends Subchapter C, Chapter 1467, Insurance Code, as follows:

SUBCHAPTER C. New heading: BAD FAITH PARTICIPATION

Sec. 1467.101. BAD FAITH. (a) Provides that the following conduct constitutes bad faith participation, rather than constitutes bad faith mediation, for purposes of this chapter:

(1) failing to participate in the informal settlement teleconference under Section 1467.084(d) or an arbitration or mediation under this chapter, rather than failing to participate in the mediation;

(2) failing to provide information the arbitrator or mediator believes is necessary to facilitate a decision or agreement, rather than failing to provide information the mediator believes is necessary to facilitate an agreement; or

(3) failing to designate a representative participating in the arbitration or mediation with full authority to enter into any agreement, rather than failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement.

(b) Provides that failure to reach an agreement under Subchapter B is not conclusive proof of bad faith participation, rather than providing that failure to reach an agreement is not conclusive proof of bad faith mediation.

Sec. 1467.102. PENALTIES. (a) Provides that bad faith participation or otherwise failing to comply with Subchapter B-1, rather than providing that bad faith 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) Requires the regulatory agency that issued the license or certificate of authority, except for good cause shown, on a report of a mediator and appropriate proof of bad faith participation under Subchapter B, rather than on a report of a mediator and appropriate proof of bad faith mediation, to impose an administrative penalty.

SECTION 2.17. Amends Sections 1467.151(a), (b), and (c), Insurance Code, as follows:

(a) Makes nonsubstantive changes throughout this subsection. Requires the rules adopted under this section by the commissioner and TMB or the other regulatory agency, as appropriate, 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 to:

(1) makes no changes to this subdivision;

(2) develop a form for filing a complaint, rather than 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.

Deletes Subdivision (4) and existing text relating to ensuring that enrollees are informed of the availability of mandatory mediation. Deletes Subdivision (5) and existing text requiring 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) Makes nonsubstantive changes throughout this subsection. Deletes the designation of Subdivision (1) and redesignates existing Subdivisions (2)(A)-(E) as Subdivisions (1)-(5). Requires TDI and TMB or the other appropriate regulatory agency to maintain information on each complaint filed that concerns a claim, arbitration, or mediation subject to this chapter, rather than on each complaint filed that concerns a claim or mediation subject to this chapter and related to a claim that is the basis of an enrollee complaint, including:

(1) the type of services or supplies, rather than type of services, that gave rise to the dispute;

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

(3) and (4) makes no further changes to these subdivisions; and

(5) any other information about:

(A) the health benefit plan issuer or administrator, rather than the insurer or administrator, that the commissioner by rule requires; or

(B) the out-of-network provider, rather than the facility-based provider or emergency care provider, that TMB or the other appropriate regulatory agency by rule requires.

(c) Provides that the information collected and maintained under Subsection (b), rather than collected and maintained by TDI and TMB and other appropriate regulatory agencies under Subsection (b)(2), is public information as defined by Section 552.002 (Definition of Public Information; Media Containing Public Information), Government Code, and may not include personally identifiable information or health care or medical information.

ARTICLE 3. CONFORMING AMENDMENTS

SECTION 3.01. Amends Section 1456.003(a), Insurance Code, as follows:

(a) Requires each health benefit plan that provides health care through a provider network to provide notice to its enrollees that:

(1) makes no changes to this subdivision; and

(2) a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan unless the health care or medical service or supply provided to the enrollee is subject to a law prohibiting balance billing.

SECTION 3.02. Amends Section 1456.006, Insurance Code, as follows:

Sec. 1456.006. COMMISSIONER RULES; FORM OF DISCLOSURE. Requires the form of certain disclosure prescribed by the commissioner by rule to contain certain language and sets forth that language, including the statement that "YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

SECTION 3.03. Repealer: Section 1456.004(c) (relating to requiring certain facility-based physicians to send a billing statement to the patient that contains a conspicuous, plain-language explanation of the mandatory mediation process available), Insurance Code.

Repealer Section 1467.001(2) (relating to the definition of "chief administrative law judge"), Insurance Code.

Repealer: Section 1467.051(c) (relating to requiring that a facility-based provider provide a complete disclosure to an enrollee), Insurance Code.

Repealer: Section 1467.051(d) (relating to prohibiting a facility-based provider who makes a certain disclosure from being required to mediate a billed charge), Insurance Code.

Repealer: Section 1467.0511 (Notice and Information Provided to Enrollee), Insurance Code.

Repealer: Section 1467.053(b) (relating to requiring the chief administrative law judge to appoint a mediator through a random assignment from a certain list of qualified mediators), Insurance Code.

Repealer: Section 1467.053(c) (relating to authorizing a person other than a mediator appointed by the chief administrative law judge, notwithstanding Subsection (b), to conduct the mediation on agreement of all of the parties and notice to the chief administrative law judge), Insurance Code.

Repealer: Section 1467.054(b) (relating to requiring a request for mandatory mediation to be provided to TDI on a form prescribed by the commissioner and to include certain information), Insurance Code.

Repealer: Section 1467.054(c) (relating to requiring TDI, on receipt of a request for mediation, to notify the facility-based provider or emergency care provider and insurer or administrator of the request), Insurance Code.

Repealer: Section 1467.054(f) (relating to authorizing the enrollee to elect to participate in the mediation), Insurance Code.

Repealer: Section 1467.054(g) (relating to authorizing mediation, notwithstanding Subsection (f), to proceed without the participation of the enrollee or the enrollee's representative if the enrollee or representative is not present in person or through teleconference), Insurance Code.

Repealer: Section 1467.055(d) (relating to requiring the mediator, if the enrollee is participating in the mediation in person, at the beginning of the mediation, to inform the enrollee that, if the enrollee is not satisfied with the mediated agreement, the enrollee may file a complaint with certain parties), Insurance Code.

Repealer: Section 1467.055(h) (relating to prohibiting the facility-based provider or emergency care provider, on receipt of certain notice, from pursuing any collection effort from certain enrollees before the earlier of certain dates), Insurance Code.

Repealer: Section 1467.057 (No Agreed Resolution), Insurance Code.

Repealer: Section 1467.058 (Continuation of Mediation), Insurance Code.

Repealer: Section 1467.059 (Mediation Agreement), Insurance Code.

Repealer: Section 1467.151(d) (relating to providing that a facility-based provider or emergency care provider who fails to provide a certain disclosure is not subject to discipline by regulatory agencies and that a cause of action is not created by such failure), Insurance Code.

ARTICLE 4. STUDY

SECTION 4.01. Amends Subchapter A, Chapter 38, Insurance Code, by adding Section 38.004, as follows:

Sec. 38.004. **BALANCE BILLING PROHIBITION REPORT.** (a) Requires TDI, each biennium, to 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) trends and changes in the amounts paid to participating providers;
- (5) 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 enrollees for amounts greater than the enrollee's responsibility under an applicable health benefit plan, including applicable copayments, coinsurance, and deductibles;
- (6) trends in amounts paid to out-of-network providers;
- (7) 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
- (8) the effectiveness of the claim dispute resolution process under Chapter 1467.

(b) Requires TDI, in conducting the study described by Subsection (a), to collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Chapter 1467.

(c) Prohibits TDI from publishing a particular rate paid to a participating provider in the study described by Subsection (a), identifying information of a physician or

health care provider, or non-aggregated study results. Provides that information described by this subsection is confidential and not subject to disclosure under Chapter 552, Government Code.

(d) Provides that TDI:

(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 (e).

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

ARTICLE 5. TRANSITION AND EFFECTIVE DATE

SECTION 5.01. Makes application of this Act prospective to January 1, 2020.

SECTION 5.02. Effective date: September 1, 2019.