By: Muñoz, Jr., Martinez, Guillen, Guerra H.B. No. 2151

A BILL TO BE ENTITLED

AN ACT

relating to the use of extrapolation by a health maintenance organization or an insurer to audit claims.

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

SECTION 1. Section 843.010, Insurance Code, is amended to read as follows:

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f), 843.322, and 843.363(a)(4) do not apply to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 533, Government Code.

SECTION 2. Subchapter I, Chapter 843, Insurance Code, is amended by adding Section 843.322 to read as follows:

Sec. 843.322. USE OF EXTRAPOLATION PROHIBITED. (a) In this section, "extrapolation" means a mathematical process or technique used by a health maintenance organization in the audit of a participating physician or provider to estimate audit results or findings for a larger batch or group of claims not reviewed by the health maintenance organization.

(b) A health maintenance organization may not use extrapolation to complete an audit of a participating physician or

provider. Any additional payment due a participating physician or provider or any refund due the health maintenance organization must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

SECTION 3. Subchapter B, Chapter 1301, Insurance Code, is amended by adding Section 1301.0642 to read as follows:

Sec. 1301.0642. USE OF EXTRAPOLATION PROHIBITED. (a) In this section, "extrapolation" means a mathematical process or technique used by an insurer in the audit of a preferred or nonpreferred provider to estimate audit results or findings for a larger batch or group of claims not reviewed by the insurer.

(b) An insurer may not use extrapolation to complete an audit of a preferred or nonpreferred provider. Any additional payment due a preferred or nonpreferred provider or any refund due the insurer must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

(c) If a payment for which a patient has signed an agreement to pay is due a preferred or nonpreferred provider, the patient is considered to have assumed full financial responsibility for the payment, and the payment may not be used as a basis for a claim of nonpayment against the insurer.

SECTION 4. The change in law made by this Act applies only to the audit of a physician or provider under a contract with an insurer or health maintenance organization entered into or renewed on or after the effective date of this Act.

SECTION 5. This Act takes effect September 1, 2019.