By: Martinez Fischer H.B. No. 3933

A BILL TO BE ENTITLED

AN ACT

relating to consumer protections against billing and limitations on information reported by consumer reporting agencies.

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

ARTICLE 1. LIMITATIONS ON SURPRISE BILLING INFORMATION REPORTED BY CONSUMER REPORTING AGENCIES

SECTION 1.01 Section 20.05, Business & Commerce Code, is amended by amending Subsection (a) and adding Subsection (d) to read as follows:

(a) Except as provided by Subsection (b), a consumer reporting agency may not furnish a consumer report containing information related to:

(1) a case under Title 11 of the United States Code or under the federal Bankruptcy Act in which the date of entry of the order for relief or the date of adjudication predates the consumer report by more than 10 years;

(2) a suit or judgment in which the date of entry predates the consumer report by more than seven years or the governing statute of limitations, whichever is longer;

(3) a tax lien in which the date of payment predates the consumer report by more than seven years;

(4) a record of arrest, indictment, or conviction of a crime in which the date of disposition, release, or parole predates the consumer report by more than seven years; [~~or~~]

(5) a collection account with a medical industry code, if the consumer was covered by a health benefit plan at the time of the event giving rise to the collection and the collection is for an outstanding balance, after copayments, deductibles, and coinsurance, owed to an emergency care provider or a facility-based provider for an out-of-network benefit claim; or

(6) another item or event that predates the consumer report by more than seven years.

(d) In this section:

(1) "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides emergency care.

(2) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(3) "Facility-based provider" means a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.

(4) "Health care practitioner" means an individual who is licensed to provide health care services.

ARTICLE 2. ELIMINATION OF SURPRISE BILLING FOR CERTAIN HEALTH BENEFIT PLANS

SECTION 2.01. Section 1271.155, Insurance Code, is amended by amending Subsection (a) and adding Subsection (f) to read as follows:

(a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers in an amount that the organization determines is reasonable for the

emergency care [~~at the usual and customary rate~~] or at an agreed rate.

(f) A non-network physician or provider may not bill a patient described by this section in, and the patient has no financial responsibility for, an amount greater than the patient's responsibility under the patient's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.02. Subchapter D, Chapter 1271, Insurance Code, is amended by adding Section 1271.157 to read as follows:

Sec. 1271.157. NON-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) A health maintenance organization shall pay for a health care service performed by a non-network provider who is a facility-based provider in an amount that the organization determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a network provider.

(c) A non-network facility-based provider may not bill a patient receiving a health care service described by Subsection (b) in, and the patient does not have financial responsibility for, an amount greater than the patient's responsibility under the patient's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.03. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1276 to read as follows:

CHAPTER 1276. ELECTIVE PROVISIONS FOR SELF-FUNDED OR SELF-INSURED MANAGED CARE PLANS

Sec. 1276.0001. DEFINITIONS. In this chapter:

(1) "Eligible plan" means a managed care plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

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

(3) "Facility-based provider" means a physician or health care provider who provides health care services to patients of a health care facility.

(4) "Managed care plan" means a health benefit plan under which the plan administrator provides or arranges for health care benefits to plan participants and requires or encourages plan participants to use physicians and health care providers the plan designates.

(5) "Out-of-network provider" means, with respect to an eligible plan, a physician or health care provider who is not a participating provider.

(6) "Participating provider" means a physician or health care provider who has contracted with an eligible plan administrator to provide services to enrollees.

Sec. 1276.0002. ELECTION FOR SURPRISE HEALTH CARE BILLING PROHIBITION AND MEDIATION. (a) A plan sponsor of an eligible plan may elect on an annual basis for this section and Chapter 1467 to

apply to the plan. A sponsor making an election shall provide written notice of the election to the department in the form and manner required by department rule.

(b) An administrator of an eligible plan for which an election is made under Subsection (a) shall pay for a health care service performed by an out-of-network provider in an amount that the administrator determines is reasonable for the service or at an agreed rate if:

(1) the provider is a facility-based provider who performed the service at a health care facility that is a participating provider; or

(2) the service is emergency care.

(c) An out-of-network provider described by Subsection (b) may not bill the patient in, and the patient does not have financial responsibility for, an amount greater than the patient's responsibility under the patient's eligible plan, including an applicable copayment, coinsurance, or deductible.

(d) An administrator of an eligible plan for which an election is made under Subsection (a) shall ensure that the plan and any evidence of coverage complies with this section and Chapter 1467.

SECTION 2.04. Section 1301.0053, Insurance Code, is amended to read as follows:

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. (a) If 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

nonpreferred provider in an amount that the issuer determines is reasonable for the emergency care services [~~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.

(b) An out-of-network provider may not bill an insured receiving emergency care in, and the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's exclusive provider benefit plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.05. 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 in an amount that the insurer determines is reasonable for the services 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.

(c) For purposes of Subsection (b), an out-of-network provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's preferred provider benefit plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.06. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.164 to read as follows:

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDER. (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) An insurer shall pay for a health care service performed by a nonpreferred provider who is a facility-based provider in an amount that the insurer determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(c) A nonpreferred provider who is a facility-based provider may not bill an insured receiving a health care service described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.07. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Sections 1551.228 and 1551.229 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 an out-of-network provider in an amount that the administrator determines is reasonable for the emergency care or at an agreed rate.

(d) For the purposes of Subsection (c), an out-of-network provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

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 out-of-network facility-based provider must provide coverage for participants in accordance with this section.

(c) The coverage must require the administrator of the plan to pay for a health care service performed for an enrollee by an out-of-network provider who is a facility-based provider in an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider performed the service

at a health care facility that is a participating provider.

(d) An out-of-network provider who is a facility-based provider may not bill an enrollee receiving a health care service described by Subsection (c) in, and the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.08. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Sections 1575.171 and 1575.172 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 offered 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 an out-of-network provider in an amount that the administrator determines is reasonable for the emergency care or at an agreed rate.

(d) For the purposes of Subsection (c), an out-of-network provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

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 offered under the group program must provide out-of-network facility-based provider coverage in accordance with this section.

(c) The coverage must require the administrator of the plan to pay for a health care service performed for an enrollee by an out-of-network provider who is a facility-based provider in an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(d) An out-of-network provider who is a facility-based provider may not bill an enrollee receiving a health care service described by Subsection (c) in, and the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.09. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Sections 1579.109 and 1579.110 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 for an enrollee by an out-of-network provider in an amount that the administrator determines is reasonable for the emergency care or at an agreed rate.

(d) For the purposes of Subsection (c), an out-of-network provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

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 in accordance with this section.

(c) The coverage must require the administrator of the plan to pay for a health care service performed for an enrollee by an out-of-network provider who is a facility-based provider in an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(d) An out-of-network provider who is a facility-based provider may not bill an enrollee receiving a health care service described by Subsection (c) in, and the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an

applicable copayment, coinsurance, or deductible.

ARTICLE 3. MANDATORY MEDIATION REQUESTED BY PROVIDER, ISSUER, OR ADMINISTRATOR

SECTION 3.01. Sections 1467.001(1), (3), (5), and (7), Insurance Code, are amended to read as follows:

(1) "Administrator" means:

(A) an administering firm for a health benefit plan providing coverage under Chapter 1551, 1575, or 1579; [~~and~~]

(B) if applicable, the claims administrator for the health benefit plan; and

(C) if applicable, an administrating firm for an eligible plan for which an election is made under Section 1276.0002.

(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~~].

(5) "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the health [~~insurer offering a preferred provider~~] benefit plan issuer or the administrator and a facility-based provider or emergency care provider or the provider's representative to settle a health benefit claim of an enrollee.

(7) "Party" means a health benefit plan issuer [~~an insurer~~] offering a health [~~a preferred provider~~] benefit plan, an administrator, or a facility-based provider or emergency care provider or the provider's representative who participates in a

mediation conducted under this chapter. [~~The enrollee is also considered a party to the mediation.~~]

SECTION 3.02. Sections 1467.002 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 health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579 or of an eligible plan for which an election is made under Section 1276.0002.

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) 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 3.03. Sections 1467.051(a) and (b), Insurance Code, are amended to read as follows:

(a) A facility-based provider, emergency care provider, health benefit plan issuer, or administrator [~~An enrollee~~] may

request mediation of a settlement of an out-of-network health benefit claim if:

(1) the amount charged 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, [~~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 preferred provider or that has a contract with the administrator.

(b) If a person [~~Except as provided by Subsections (c) and (d), if an enrollee~~] requests mediation under this subchapter, the 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 mediation.

SECTION 3.04. Section 1467.052(c), Insurance Code, is amended to read as follows:

(c) A person may not act 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 of a health [~~an insurer offering the preferred provider~~] benefit plan that is subject to this chapter or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request

for mediation.

SECTION 3.05. Section 1467.053(d), Insurance Code, is amended to read as follows:

(d) The mediator's fees shall be split evenly and paid by the health benefit plan issuer [~~insurer~~] or administrator and the facility-based provider or emergency care provider.

SECTION 3.06. Sections 1467.054(a), (b), (c), and (d), Insurance Code, are amended to read as follows:

(a) A facility-based provider, emergency care provider, health benefit plan issuer, or administrator [~~An enrollee~~] may request mandatory mediation under this subchapter [~~chapter~~].

(b) A request for mandatory mediation must be provided to the department on a form prescribed by the commissioner and must include:

(1) the name of the person [~~enrollee~~] requesting mediation;

(2) a brief description of the claim to be mediated;

(3) contact information, including a telephone number, for the requesting person [~~enrollee~~] and the person's [~~enrollee's~~] counsel, if the person [~~enrollee~~] retains counsel;

(4) the name of the facility-based provider or emergency care provider and name of the health benefit plan issuer [~~insurer~~] or administrator; and

(5) any other information the commissioner may require by rule.

(c) On receipt of a request for mediation, the department shall notify, as applicable, the facility-based provider or

emergency care provider and health benefit plan issuer [~~insurer~~] or administrator of the request.

(d) In an effort to settle the claim before mediation, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which a person [~~the enrollee~~] submits a request for mediation under this subchapter [~~section~~].

SECTION 3.07. Section 1467.055(g), Insurance Code, is amended to read as follows:

(g) A [~~Except at the request of an enrollee, a~~] mediation shall be held not later than the 180th day after the date of the request for mediation.

SECTION 3.08. Sections 1467.056(a), (b), and (d), Insurance Code, are amended to read as follows:

(a) In a mediation under this subchapter [~~chapter~~], the parties shall[~~:~~

[~~(1)~~] evaluate whether:

(1) [~~(A)~~] the amount charged by the facility-based provider or emergency care provider for the health care or medical service or supply is excessive; and

(2) [~~(B)~~] the amount paid by the health benefit plan issuer [~~insurer~~] or administrator represents a reasonable amount [~~the usual and customary rate~~] for the health care or medical service or supply or is unreasonably low[~~; and~~

[~~(2) as a result of the amounts described by Subdivision (1), determine the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is~~

~~responsible to the facility-based provider or emergency care provider~~].

(b) The facility-based provider or emergency care provider may present information regarding the amount charged for the health care or medical service or supply. The health benefit plan issuer [~~insurer~~] or administrator may present information regarding the amount paid by the issuer [~~insurer~~] or administrator.

(d) The goal of the mediation is to reach an agreement among [~~the enrollee,~~] the facility-based provider or emergency care provider[~~,~~] and the health benefit plan issuer [~~insurer~~] or administrator, as applicable, as to the amount paid by the issuer [~~insurer~~] or administrator to the facility-based provider or emergency care provider and[~~,~~] 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 3.09. Sections 1467.058 and 1467.059, Insurance Code, are amended to read as follows:

Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral is made under Section 1467.057, the facility-based provider or emergency care provider and the health benefit plan issuer [~~insurer~~] or administrator may elect to continue the mediation to further determine their responsibilities. [~~Continuation of mediation under this section does not affect the amount of the billed charge to the enrollee.~~]

Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall prepare a confidential mediation agreement and order that states[~~:~~

[~~(1) the total amount for which the enrollee will be responsible to the facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance; and~~

[~~(2)~~] any agreement reached by the parties under Section 1467.058.

SECTION 3.10. Section 1467.101(a), Insurance Code, is amended to read as follows:

(a) The following conduct constitutes bad faith mediation for purposes of this chapter:

(1) failing to participate in the mediation;

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

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

(4) failing to appear for mediation.

SECTION 2.11. Section 1467.151(b), Insurance Code, is amended to read as follows:

(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 mediation subject to this chapter; and

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

(A) the type of services that gave rise to the dispute;

(B) the type and specialty, if any, of the

facility-based provider or emergency care provider who provided the out-of-network service;

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

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

(E) any other information about:

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

(ii) the facility-based provider or emergency care provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.

ARTICLE 4. CONFORMING AMENDMENTS

SECTION 4.01. 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 1271.155, 1301.164, 1551.229, 1575.172, or 1579.110, or an eligible plan for which an election is made under Section 1276.0002.

SECTION 4.02. The following provisions of the Insurance Code are repealed:

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

(2) Section 1467.0511;

(3) Sections 1467.054(f) and (g);

(4) Section 1467.055(d); and

(5) Section 1467.151(d).

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 the effective date of this Act. A health care or medical service or supply provided before the effective date of this Act 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 4.02. This Act takes effect September 1, 2019.