

By: Hancock, et al.

S.B. No. 1264

A BILL TO BE ENTITLED

AN ACT

relating to consumer protections against certain medical and health care billing by certain out-of-network providers; authorizing a fee.

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

ARTICLE 1. ELIMINATION OF SURPRISE BILLING FOR CERTAIN HEALTH

BENEFIT PLANS

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

CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

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

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

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

13 (b) A regulatory agency described by Subsection (a) may
14 adopt rules as necessary to implement this section. Section
15 2001.0045, Government Code, does not apply to rules adopted under
16 this subsection.

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

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

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

27 (2) the amount the physician or provider may bill the

1 enrollee under the enrollee's health benefit plan; and

2 (3) for an explanation of benefits provided to the
3 physician or provider, information required by commissioner rule
4 advising the physician or provider of the availability of the
5 out-of-network claim dispute resolution process under Chapter
6 1467.

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

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

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

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

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

24 (3) services originated in a hospital emergency
25 facility, freestanding emergency medical care facility, or
26 comparable emergency facility following treatment or stabilization
27 of an emergency medical condition shall be provided to covered

1 enrollees as approved by the health maintenance organization,
2 subject to Subsections (c) and (d); and

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

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

12 (1) is based on:

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

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

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

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

23 Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS.

24 (a) In this section, "facility-based provider" means a physician
25 or provider who provides health care services to patients of a
26 health care facility.

27 (b) Except as provided by Subsection (d), a health

1 maintenance organization shall pay for a health care service
2 performed for or a supply related to that service provided to an
3 enrollee by a non-network physician or provider who is a
4 facility-based provider at the usual and customary rate or at an
5 agreed rate if the provider performed the service at a health care
6 facility that is a network provider.

7 (c) Except as provided by Subsection (d), a non-network
8 facility-based provider or a person asserting a claim as an agent or
9 assignee of the provider may not bill an enrollee receiving a health
10 care service or supply described by Subsection (b) in, and the
11 enrollee does not have financial responsibility for, an amount
12 greater than an applicable copayment, coinsurance, or deductible
13 under the enrollee's health care plan that:

14 (1) is based on:

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

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

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

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

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

27 (2) with notice of the enrollee's potential financial

1 responsibility from each non-network physician or provider
2 providing the service.

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

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

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

22 (1) is based on:

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

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

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

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

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

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

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

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

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

27 (1) is based on:

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

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

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

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

9 Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An
10 insurer shall provide written notice in accordance with this
11 subsection in an explanation of benefits provided to the insured
12 and the physician or health care provider in connection with a
13 health care service or supply that is subject to Section 1301.0053,
14 1301.155, 1301.164, or 1301.165. The notice must include:

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

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

19 (3) for an explanation of benefits provided to the
20 physician or provider, information required by commissioner rule
21 advising the physician or provider of the availability of the
22 out-of-network claim dispute resolution process under Chapter
23 1467.

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

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

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

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

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

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

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

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

1 (1) is based on:

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

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

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

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

11 Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS.

12 (a) In this section, "facility-based provider" means a physician
13 or health care provider who provides health care services to
14 patients of a health care facility.

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

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

1 benefit plan that:

2 (1) is based on:

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

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

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

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

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

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

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

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

27 (c) Except as provided by Subsection (d), an out-of-network

1 provider who is a diagnostic imaging provider or laboratory service
2 provider or a person asserting a claim as an agent or assignee of
3 the provider may not bill an insured receiving a medical care or
4 health care service or supply described by Subsection (b) in, and
5 the insured does not have financial responsibility for, an amount
6 greater than an applicable copayment, coinsurance, or deductible
7 under the insured's preferred provider benefit plan that:

8 (1) is based on:

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

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

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

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

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

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

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

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

27 SECTION 1.10. Subchapter A, Chapter 1551, Insurance Code,

1 is amended by adding Section 1551.015 to read as follows:

2 Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE.

3 (a) The administrator of a managed care plan provided under the
4 group benefits program shall provide written notice in accordance
5 with this subsection in an explanation of benefits provided to the
6 participant and the physician or health care provider in connection
7 with a health care service or supply that is subject to Section
8 1551.228, 1551.229, or 1551.230. The notice must include:

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

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

13 (3) for an explanation of benefits provided to the
14 physician or provider, information required by commissioner rule
15 advising the physician or provider of the availability of the
16 out-of-network claim dispute resolution process under Chapter
17 1467.

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

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

25 Sec. 1551.228. EMERGENCY CARE COVERAGE. (a) In this
26 section, "emergency care" has the meaning assigned by Section
27 1301.155.

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

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

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

15 (1) is based on:

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

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

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

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

26 (b) A managed care plan provided under the group benefits
27 program must provide out-of-network facility-based provider

1 coverage for participants in accordance with this section.

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

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

17 (1) is based on:

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

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

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

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

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

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

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

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

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

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

1 (1) is based on:

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

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

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

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

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

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

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

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

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

22 Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE.

23 (a) The administrator of a managed care plan provided under the
24 group program shall provide written notice in accordance with this
25 subsection in an explanation of benefits provided to the enrollee
26 and the physician or health care provider in connection with a
27 health care service or supply that is subject to Section 1575.171,

1 1575.172, or 1575.173. The notice must include:

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

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

6 (3) for an explanation of benefits provided to the
7 physician or provider, information required by commissioner rule
8 advising the physician or provider of the availability of the
9 out-of-network claim dispute resolution process under Chapter
10 1467.

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

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

18 Sec. 1575.171. EMERGENCY CARE COVERAGE. (a) In this
19 section, "emergency care" has the meaning assigned by Section
20 1301.155.

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

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

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

8 (1) is based on:

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

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

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

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

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

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

1 facility that is a participating provider.

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

10 (1) is based on:

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

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

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

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

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

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

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

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

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

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

21 (1) is based on:

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

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

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

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

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

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

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

10 Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE.

11 (a) The administrator of a managed care plan provided under this
12 chapter shall provide written notice in accordance with this
13 subsection in an explanation of benefits provided to the enrollee
14 and the physician or health care provider in connection with a
15 health care service or supply that is subject to Section 1579.109,
16 1579.110, or 1579.111. The notice must include:

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

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

21 (3) for an explanation of benefits provided to the
22 physician or provider, information required by commissioner rule
23 advising the physician or provider of the availability of the
24 out-of-network claim dispute resolution process under Chapter
25 1467.

26 (b) A physician or health care provider that provides a
27 service or supply described by Subsection (a) shall provide notice

1 of the prohibitions described by Subsection (a)(1) in an invoice
2 for the service or supply provided to an enrollee.

3 SECTION 1.16. Subchapter C, Chapter 1579, Insurance Code,
4 is amended by adding Sections 1579.109, 1579.110, and 1579.111 to
5 read as follows:

6 Sec. 1579.109. EMERGENCY CARE COVERAGE. (a) In this
7 section, "emergency care" has the meaning assigned by Section
8 1301.155.

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

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

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

23 (1) is based on:

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

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

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

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

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

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

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

25 (1) is based on:

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

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

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

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

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

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

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

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

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

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

9 (1) is based on:

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

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

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

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

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

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

23 ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

24 SECTION 2.01. Section 1467.001, Insurance Code, is amended
25 by adding Subdivisions (1-a), (2-c), (2-d), (4-b), and (6-a) and
26 amending Subdivisions (2-a), (2-b), (3), (5), and (7) to read as
27 follows:

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

5 (2-a) "Diagnostic imaging provider" means a health
6 care provider who performs a diagnostic imaging service on a
7 patient for a fee or interprets imaging produced by a diagnostic
8 imaging service.

9 (2-b) "Diagnostic imaging service" means magnetic
10 resonance imaging, computed tomography, positron emission
11 tomography, or any hybrid technology that combines any of those
12 imaging modalities.

13 (2-c) "Emergency care" has the meaning assigned by
14 Section 1301.155.

15 (2-d) [~~(2-b)~~] "Emergency care provider" means a
16 physician, health care practitioner, facility, or other health care
17 provider who provides and bills an enrollee, administrator, or
18 health benefit plan for emergency care.

19 (3) "Enrollee" means an individual who is eligible to
20 receive benefits through a [preferred provider benefit plan or a]
21 health benefit plan subject to this chapter [under Chapter 1551,
22 1575, or 1579].

23 (4-b) "Laboratory service provider" means an
24 accredited facility in which a specimen taken from a human body is
25 interpreted and pathological diagnoses are made or a person who
26 makes an interpretation of or diagnosis based on a specimen or
27 information provided by a laboratory based on a specimen.

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

7 (6-a) "Out-of-network provider" means a diagnostic
8 imaging provider, emergency care provider, facility-based
9 provider, or laboratory service provider that is not a
10 participating provider for a health benefit plan.

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

18 SECTION 2.02. Sections [1467.002](#), [1467.003](#), and [1467.005](#),
19 Insurance Code, are amended to read as follows:

20 Sec. 1467.002. APPLICABILITY OF CHAPTER. (a) This
21 chapter, other than Subchapter B-1, applies to:

22 (1) a preferred provider benefit plan, including an
23 exclusive provider benefit plan, offered by an insurer under
24 Chapter [1301](#); and

25 (2) a health benefit plan offered by [~~an administrator~~
26 ~~of a health benefit plan, other than~~] a health maintenance
27 organization operating under Chapter [843](#) [~~plan, under Chapter [1551](#),~~

1 ~~1575, or 1579~~].

2 (b) This chapter, other than Subchapter B, applies to an
3 administrator of a health benefit plan, other than a health
4 maintenance organization plan, under Chapter 1551, 1575, or 1579.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (b) The commissioner:

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

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

25 Sec. 1467.0505. ISSUE TO BE ADDRESSED; BASIS FOR
26 DETERMINATION. (a) The only issue that an arbitrator may
27 determine under this subchapter is the reasonable amount for the

1 health care or medical services or supplies provided to the
2 enrollee by an out-of-network provider.

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

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

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

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

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

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

17 (4) the circumstances and complexity of the enrollee's
18 particular case, including the time and place of the provision of
19 the service or supply;

20 (5) individual enrollee characteristics;

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

26 (7) the 50th percentile of rates for the service or
27 supply paid to participating providers in the same or similar

1 specialty and provided in the same geographical area as reported in
2 a benchmarking database described by Section 1467.006.

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

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

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

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

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

20 (2) the health benefit claim is for:

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

22 (B) a health care or medical service or supply
23 provided by a facility-based provider in a facility that is a
24 participating ~~[preferred]~~ provider;

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

26 (D) an out-of-network diagnostic imaging service
27 ~~[that has a contract with the administrator]~~.

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

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

10 (1) the department; and

11 (2) each other party.

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

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

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

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

27 (b) An arbitration conducted under this subchapter is not

1 subject to Title 7, Civil Practice and Remedies Code.

2 SECTION 2.09. Subchapter B, Chapter 1467, Insurance Code,
3 is amended by adding Sections 1467.0535, 1467.0545, 1467.0555, and
4 1467.0565 to read as follows:

5 Sec. 1467.0535. SELECTION AND APPROVAL OF ARBITRATOR.

6 (a) If the parties do not select an arbitrator by mutual agreement
7 on or before the 30th day after the date the arbitration is
8 requested, the party requesting the arbitration shall notify the
9 commissioner, and the commissioner shall select an arbitrator from
10 the commissioner's list of approved arbitrators.

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

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

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

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

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

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

5 (1) may not consider medical records that were not
6 presented to the health benefit plan issuer during an appeals
7 process offered by the issuer or administrator to resolve an
8 out-of-network claim;

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

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

14 (e) The parties shall evenly split and pay the arbitrator's
15 fees and expenses.

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

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

24 (A) the provider may revise the billed amount to
25 correct a billing error before the completion of an appeal process
26 offered by the issuer or administrator to resolve an out-of-network
27 claim; and

1 (B) the health benefit plan issuer may increase
2 the initial payment under the appeal process offered by the issuer
3 or administrator to resolve an out-of-network claim; and

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

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

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

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

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

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

21 SECTION 2.10. Chapter 1467, Insurance Code, is amended by
22 adding Subchapter B-1 to read as follows:

23 SUBCHAPTER B-1. MANDATORY MEDIATION

24 Sec. 1467.081. AVAILABILITY OF MANDATORY MEDIATION.

25 (a) An out-of-network provider or administrator may request
26 mediation of a settlement of an out-of-network health benefit claim
27 arising from a health benefit plan to which this subchapter applies

1 if:

2 (1) there is an amount billed by the provider and
3 unpaid by the administrator after copayments, deductibles, and
4 coinsurance for which an enrollee may not be billed; and

5 (2) the health benefit claim is for:

6 (A) emergency care;

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

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

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

13 (b) If a person requests mediation under this subchapter,
14 the out-of-network provider, or the provider's representative, and
15 the administrator shall participate in the mediation.

16 Sec. 1467.082. MEDIATOR QUALIFICATIONS. (a) Except as
17 provided by Subsection (b), to qualify for an appointment as a
18 mediator under this subchapter a person must have completed at
19 least 40 classroom hours of training in dispute resolution
20 techniques in a course conducted by an alternative dispute
21 resolution organization or other dispute resolution organization
22 approved by the chief administrative law judge.

23 (b) A person not qualified under Subsection (a) may be
24 appointed as a mediator on agreement of the parties.

25 (c) A person may not act as mediator for a claim settlement
26 dispute if the person has been employed by, consulted for, or
27 otherwise had a business relationship with an administrator of a

1 health benefit plan that is subject to this subchapter or a
2 physician, health care practitioner, or other health care provider
3 during the three years immediately preceding the request for
4 mediation.

5 Sec. 1467.083. APPOINTMENT OF MEDIATOR; FEES. (a) A
6 mediation shall be conducted by one mediator.

7 (b) The chief administrative law judge shall appoint the
8 mediator through a random assignment from a list of qualified
9 mediators maintained by the State Office of Administrative
10 Hearings.

11 (c) Notwithstanding Subsection (b), a person other than a
12 mediator appointed by the chief administrative law judge may
13 conduct the mediation on agreement of all of the parties and notice
14 to the chief administrative law judge.

15 (d) The mediator's fees shall be split evenly and paid by
16 the administrator and the out-of-network provider.

17 Sec. 1467.084. REQUEST AND PRELIMINARY PROCEDURES FOR
18 MANDATORY MEDIATION. (a) An out-of-network provider or
19 administrator may request mandatory mediation under this
20 subchapter.

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

- 24 (1) the name of the person requesting mediation;
25 (2) a brief description of the claim to be mediated;
26 (3) contact information, including a telephone
27 number, for the requesting person and the person's counsel, if the

1 person retains counsel;

2 (4) the name of the out-of-network provider and name
3 of the administrator; and

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

6 (c) On receipt of a request for mediation, the department
7 shall notify the out-of-network provider or the administrator of
8 the request.

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

13 (e) A dispute to be mediated under this subchapter that does
14 not settle as a result of a teleconference conducted under
15 Subsection (d) must be conducted in the county in which the health
16 care or medical services were rendered.

17 Sec. 1467.085. CONDUCT OF MEDIATION; CONFIDENTIALITY.

18 (a) A mediator may not impose the mediator's judgment on a party
19 about an issue that is a subject of the mediation.

20 (b) A mediation session is under the control of the
21 mediator.

22 (c) Except as provided by this chapter, the mediator must
23 hold in strict confidence all information provided to the mediator
24 by a party and all communications of the mediator with a party.

25 (d) A party must have an opportunity during the mediation to
26 speak and state the party's position.

27 (e) Except on the agreement of the participating parties, a

1 mediation may not last more than four hours.

2 (f) A mediation shall be held not later than the 180th day
3 after the date of the request for mediation.

4 (g) A health care or medical service or supply provided by
5 an out-of-network provider may not be summarily disallowed. This
6 subsection does not require an administrator to pay for an
7 uncovered service or supply.

8 (h) A mediator may not testify in a proceeding, other than a
9 proceeding to enforce this chapter, related to the mediation
10 agreement.

11 Sec. 1467.086. MATTERS CONSIDERED IN MEDIATION; AGREED
12 RESOLUTION. (a) In a mediation under this subchapter, the parties
13 shall evaluate whether:

14 (1) the amount charged by the out-of-network provider
15 for the health care or medical service or supply is excessive; and

16 (2) the amount paid by the administrator represents
17 the usual and customary rate for the health care or medical service
18 or supply or is unreasonably low.

19 (b) The out-of-network provider may present information
20 regarding the amount charged for the health care or medical service
21 or supply. The administrator may present information regarding the
22 amount paid by the administrator.

23 (c) Nothing in this chapter prohibits mediation of more than
24 one claim between the parties during a mediation.

25 (d) The goal of the mediation is to reach an agreement
26 between the out-of-network provider and the administrator as to the
27 amount paid by the administrator to the provider and the amount

1 charged by the provider.

2 Sec. 1467.087. NO AGREED RESOLUTION. (a) The mediator of
3 an unsuccessful mediation under this subchapter shall report the
4 outcome of the mediation to the department, the Texas Medical Board
5 or other appropriate regulatory agency, and the chief
6 administrative law judge.

7 (b) The chief administrative law judge shall enter an order
8 of referral of a matter reported under Subsection (a) to a special
9 judge under Chapter 151, Civil Practice and Remedies Code, that:

10 (1) names the special judge on whom the parties agreed
11 or appoints the special judge if the parties did not agree on a
12 judge;

13 (2) states the issues to be referred and the time and
14 place on which the parties agree for the trial;

15 (3) requires each party to pay the party's
16 proportionate share of the special judge's fee; and

17 (4) certifies that the parties have waived the right
18 to trial by jury.

19 (c) A trial by the special judge selected or appointed as
20 described by Subsection (b) must proceed under Chapter 151, Civil
21 Practice and Remedies Code, except that the special judge's verdict
22 is not relevant or material to any other billing dispute and has no
23 precedential value.

24 (d) Notwithstanding any other provision of this section,
25 Section 151.012, Civil Practice and Remedies Code, does not apply
26 to a mediation under this subchapter.

27 Sec. 1467.088. CONTINUATION OF MEDIATION. After a referral

1 is made under Section 1467.087, the out-of-network provider and the
2 administrator may elect to continue the mediation to further
3 determine their responsibilities.

4 Sec. 1467.089. MEDIATION AGREEMENT. The mediator shall
5 prepare a confidential mediation agreement and order that states
6 any agreement reached by the parties under Section 1467.088.

7 Sec. 1467.090. REPORT OF MEDIATOR. The mediator shall
8 report to the commissioner and the Texas Medical Board or other
9 appropriate regulatory agency:

- 10 (1) the names of the parties to the mediation; and
11 (2) whether the parties reached an agreement or the
12 mediator made a referral under Section 1467.087.

13 SECTION 2.11. Subchapter C, Chapter 1467, Insurance Code,
14 is amended to read as follows:

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

16 Sec. 1467.101. BAD FAITH. (a) The following conduct
17 constitutes bad faith participation [~~mediation~~] for purposes of
18 this chapter:

19 (1) failing to participate in the informal settlement
20 teleconference under Section 1467.051(f), arbitration under
21 Subchapter B, or mediation under Subchapter B-1;

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

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

1 (4) failing to appear for the arbitration or
2 mediation.

3 (b) Failure to reach an agreement under Subchapter B-1 is
4 not conclusive proof of bad faith participation [~~mediation~~].

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

11 (b) Except for good cause shown, on a report of a mediator
12 and appropriate proof of bad faith participation under Subchapter
13 B-1 [~~mediation~~], the regulatory agency that issued the license or
14 certificate of authority shall impose an administrative penalty.

15 SECTION 2.12. Sections [1467.151](#)(a), (b), and (c), Insurance
16 Code, are amended to read as follows:

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

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

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

1 ~~chapter~~]; and

2 (3) ensure that a complaint is not dismissed without
3 appropriate consideration[+]

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

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

9 (b) The department and the Texas Medical Board or other
10 appropriate regulatory agency shall maintain information[+]

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

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

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

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

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

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

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

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

27 or

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

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

10 ARTICLE 3. CONFORMING AMENDMENTS

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

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

- 19 [~~(A) a health maintenance organization,~~
- 20 [~~(B) a preferred provider benefit plan issuer, or~~
- 21 [~~(C) another entity that issues a health benefit~~
- 22 ~~plan, including an insurance company.]~~

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

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

26 (1) provides benefits for medical or surgical expenses
27 incurred as a result of a health condition, accident, or sickness,

1 including an individual, group, blanket, or franchise insurance
2 policy or insurance agreement, a group hospital service contract,
3 or an individual or group evidence of coverage that is offered by:

4 (A) an insurance company;

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

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

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

11 (E) ~~[a health maintenance organization operating~~
12 ~~under Chapter 843,~~

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

15 (F) ~~[(G)]~~ an approved nonprofit health
16 corporation that holds a certificate of authority under Chapter
17 844; or

18 (G) ~~[(H)]~~ an entity not authorized under this
19 code or another insurance law of this state that contracts directly
20 for health care services on a risk-sharing basis, including a
21 capitation basis; or

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

26 (c) This chapter does not apply to:

27 (1) Medicaid managed care programs operated under

1 Chapter 533, Government Code;

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

4 (3) the state child health plan operated under Chapter
5 62 or 63, Health and Safety Code; or

6 (4) a health benefit plan subject to Section 1271.157,
7 1301.164, 1551.229, 1575.172, or 1579.110.

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

10 (1) Section 1456.004(c);

11 (2) Sections 1467.051(c) and (d);

12 (3) Section 1467.0511;

13 (4) Section 1467.052;

14 (5) Section 1467.053;

15 (6) Section 1467.054;

16 (7) Section 1467.055;

17 (8) Section 1467.056;

18 (9) Section 1467.057;

19 (10) Section 1467.058;

20 (11) Section 1467.059;

21 (12) Section 1467.060; and

22 (13) Section 1467.151(d).

23 ARTICLE 4. STUDY

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

26 Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (a) The
27 department shall, each biennium, conduct a study on the impacts of

1 S.B. No. 1264, Acts of the 86th Legislature, Regular Session, 2019,
2 on Texas consumers and health coverage in this state, including:

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

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

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

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

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

27 (6) trends in the usual and customary rate for health

1 care or medical services or supplies, especially emergency
2 services, laboratory services, diagnostic imaging services, and
3 facility-based services; and

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

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

9 (c) The department:

10 (1) shall collect data quarterly from a health benefit
11 plan issuer or administrator subject to Chapter 1467 to conduct the
12 study required by this section; and

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

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

20 ARTICLE 5. TRANSITION AND EFFECTIVE DATE

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

27 SECTION 5.02. The Texas Department of Insurance, the

1 Employees Retirement System of Texas, the Teacher Retirement System
2 of Texas, and any other state agency subject to this Act are
3 required to implement a provision of this Act only if the
4 legislature appropriates money specifically for that purpose. If
5 the legislature does not appropriate money specifically for that
6 purpose, those agencies may, but are not required to, implement a
7 provision of this Act using other appropriations available for that
8 purpose.

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