By: Hancock, et al. S.B. No. 1264
(Oliverson, Martinez Fischer, Bonnen of Galveston, Zerwas, Lucio III)

Substitute the following for S.B. No. 1264:

By: Lucio III C.S.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.

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 F, Title 8, Insurance Code, is amended by adding Chapter 1466 to read as follows:

CHAPTER 1466. OUT-OF-NETWORK COVERAGES AND BALANCE BILLING PROHIBITIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1466.0001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 1467.001 have the meanings assigned by that section.

Sec. 1466.0002. APPLICABILITY OF CHAPTER. This chapter applies only 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) a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.

SUBCHAPTER B. REQUIRED COVERAGES

Sec. 1466.0051. USUAL AND CUSTOMARY RATE FOR CERTAIN GOVERNMENTAL PLANS. For purposes of this subchapter, the usual and customary rate for a health benefit plan under Chapter 1551, 1575, or 1579 is the relevant allowable amount as described by the applicable master benefit plan document or policy.

Sec. 1466.0052. EMERGENCY CARE COVERAGE. A health benefit plan that provides coverage for emergency care performed for or a supply related to that care provided to an enrollee by an out-of-network provider must provide the coverage at the usual and customary rate or at an agreed rate.

Sec. 1466.0053. FACILITY-BASED PROVIDER COVERAGE; EXCEPTION. (a) Except as provided by Subsection (b), a health benefit plan that provides coverage for a health care or medical service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider must provide the coverage at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(b) This section does not apply to a nonemergency health care or medical service:

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

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

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

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

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

Sec. 1466.0054. DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER COVERAGE; EXCEPTION. (a) Except as provided by Subsection (b), a health benefit plan that provides coverage for a health care or medical service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider must provide the coverage at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care service performed by a participating provider.

(b) This section does not apply to a nonemergency health care or medical service:

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

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

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

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

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

Sec. 1466.0055. ACTION ON CLEAN CLAIMS FOR REQUIRED COVERAGES. (a) A health maintenance organization shall act on a clean claim as defined by Section 843.336 related to a health care or medical service or supply required to be covered under this subchapter in accordance with Section 843.338 as if the out-of-network provider is a participating physician or provider.

(b) An insurer shall act on a clean claim as defined by Section 1301.101 related to a health care or medical service or supply required to be covered under this subchapter in accordance with Section 1301.103 as if the out-of-network provider is a preferred provider.

(c) An administrator shall act on a clean claim as defined by Section 1301.101 related to a health care or medical service or supply required to be covered under this subchapter in accordance with Section 1301.103 as if:

(1) the out-of-network provider is a preferred provider; and

(2) the administrator is an insurer.

SUBCHAPTER C. BALANCE BILLING PROHIBITIONS

Sec. 1466.0101. BALANCE BILLING PROHIBITION NOTICE. A health benefit plan issuer or administrator shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the out-of-network provider in connection with a health care service or supply that is subject to Subchapter B. The notice must include:

(1) a statement of the billing prohibition under Section 1466.0102;

(2) the total amount the provider may bill the enrollee under the enrollee's health benefit plan and an itemization of copayments, deductibles, coinsurance, or other amounts included in that total; and

(3) for an explanation of benefits provided to the provider, information required by commissioner rule advising the provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

Sec. 1466.0102. CERTAIN BALANCE BILLING PROHIBITED. For a health care service or supply required to be covered under Subchapter B, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the health benefit plan issuer or administrator; or

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

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

SUBCHAPTER D. ENFORCEMENT

Sec. 1466.0151. INJUNCTION RELATED TO BALANCE BILLING VIOLATION. (a) If the attorney general receives a referral from the appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating Subchapter C, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation.

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

Sec. 1466.0152. ENFORCEMENT BY REGULATORY AGENCY. (a) An appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state shall take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates Section 1466.0102.

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

ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

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

follows:

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

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

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

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

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

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

(4-b) "Laboratory service provider" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a person who

makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

(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 an out-of-network [~~a facility-based~~] provider [~~or emergency care provider~~] or the provider's representative to settle a health benefit claim of an enrollee.

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

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

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

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

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

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

Chapter 1301; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner:

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

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

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

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

SECTION 2.07. Sections 1467.051(a) and (b), Insurance Code, are amended to read as follows:

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

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

(2) the health benefit claim is for:

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

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

(C) an out-of-network diagnostic imaging service [~~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 out-of-network [~~facility-based~~] provider [~~or emergency care provider,~~] or the provider's representative, and the health benefit

plan issuer [~~insurer~~] or the administrator, as appropriate, shall participate in the mediation.

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

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

(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 [~~an insurer offering the preferred provider~~] benefit plan issuer or administrator or a facility [~~physician, health care practitioner, or other health care provider~~] during the three years immediately preceding the request for mediation.

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

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

(b-1) If the parties do not select a mediator by mutual

agreement on or before the 30th day after the date the mediation is requested, the party requesting the mediation shall notify the commissioner, and the commissioner shall select a mediator from the commissioner's list of approved mediators.

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

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

(a) An out-of-network provider, health benefit plan issuer, or administrator [~~enrollee~~] may request mandatory mediation under this subchapter [~~chapter~~].

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

(1) the department; and

(2) each other party.

(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 2.11. Sections 1467.055(g) and (i), Insurance Code, are 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.

(i) A health care or medical service or supply provided by an out-of-network [~~a facility-based~~] provider [~~or emergency care provider~~] may not be summarily disallowed. This subsection does not require a health benefit plan issuer [~~an insurer~~] or administrator to pay for an uncovered service or supply.

SECTION 2.12. 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 out-of-network [~~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 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 out-of-network [~~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 between [~~among the enrollee,~~] the out-of-network [~~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 out-of-network [~~facility-based~~] provider and [~~or emergency care provider,~~] the amount charged by the out-of-network [~~facility-based~~] provider [~~or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee~~].

SECTION 2.13. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Section 1467.0575 to read as follows:

Sec. 1467.0575. RIGHT TO RECEIVE PAYMENT; RIGHT TO FILE ACTION. (a) An out-of-network provider has a right to a reasonable payment from an enrollee's health benefit plan for covered services and supplies provided to the enrollee that are subject to this subchapter and for which the provider has not been fully reimbursed.

(b) Not later than the 45th day after the date that the mediator's report is provided to the department under Section 1467.060, either party to a mediation for which there was no agreement may file a civil action to determine the amount due to an out-of-network provider. A party may not bring a civil action before the conclusion of the mediation process under this subchapter.

SECTION 2.14. Section 1467.060, Insurance Code, is amended to read as follows:

Sec. 1467.060. REPORT OF MEDIATOR. Not later than the 45th day after the date the mediation concludes, the [~~The~~] mediator shall report to the commissioner and the Texas Medical Board or other appropriate regulatory agency:

(1) the names of the parties to the mediation; and

(2) whether the parties reached an agreement [~~or the mediator made a referral under Section 1467.057~~].

SECTION 2.15. Chapter 1467, Insurance Code, is amended by adding Subchapter B-1 to read as follows:

SUBCHAPTER B-1. MANDATORY BINDING ARBITRATION FOR OTHER PROVIDERS

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

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

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on the department's Internet website through which a request for arbitration under Section 1467.084 may be submitted; and

(2) shall maintain a list of qualified arbitrators for

the program.

Sec. 1467.083. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) The only issue that an arbitrator may determine under this subchapter is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider.

(b) The determination must take into account:

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

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

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

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

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

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

(5) individual enrollee characteristics;

(6) the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geographical area as

reported in a benchmarking database described by Section 1467.006;

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

(8) historical rates paid to participating providers; and

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

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

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

(2) the health benefit claim is for:

(A) emergency care;

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

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

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

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

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

(1) the department; and

(2) each other party.

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

(e) The commissioner shall adopt rules providing requirements for submitting arbitration in one proceeding. The rules must provide that:

(1) a claim for a billed charge of $1,500 or more may not be combined with another claim;

(2) the total amount in controversy for multiple claims in one arbitration may not exceed $5,000; and

(3) the multiple claims in one arbitration must be limited to the same out-of-network provider.

Sec. 1467.085. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Notwithstanding Section 1467.004, an out-of-network provider, health benefit plan issuer, or

administrator may not file suit for an out-of-network claim subject to this chapter until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

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

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

(b) In selecting an arbitrator under this section, the commissioner shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

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

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

Sec. 1467.087. PROCEDURES. (a) The arbitrator shall set a date for submission of all information to be considered by the arbitrator.

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

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

(d) Unless otherwise agreed to by the parties, an arbitrator may not determine whether a health benefit plan covers a particular health care or medical service or supply.

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

Sec. 1467.088. DECISION. (a) Not later than the 75th day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed charge or the initial payment made by the health benefit plan issuer or administrator is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.083(b), provided that if the out-of-network provider elects to participate in the issuer's or administrator's internal appeal process before arbitration:

(A) the provider may revise the billed charge to correct a billing error before the completion of the appeal process; and

(B) the health benefit plan issuer or

administrator may increase the initial payment under the appeal process; and

(2) selects the billed charge or initial payment described by Subdivision (1) as the binding award amount.

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

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

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

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

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

(d) Not later than the 10th day after the date of an arbitrator's decision under Section 1467.088 or a court's determination in an action filed under Subsection (b), a health benefit plan issuer or administrator shall pay to an out-of-network provider any additional amount necessary to satisfy the binding

award or the court's determination, as applicable.

SECTION 2.16. Subchapter C, Chapter 1467, Insurance Code, is amended to read as follows:

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

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

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

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

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

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

Sec. 1467.102. PENALTIES. (a) Bad faith participation or otherwise failing to comply with Subchapter B-1 [~~mediation, by a party other than the enrollee,~~] is grounds for imposition of an administrative penalty by the regulatory agency that issued a license or certificate of authority to the party who committed the violation.

(b) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith participation under Subchapter B [~~mediation~~], the regulatory agency that issued the license or

certificate of authority shall impose an administrative penalty.

SECTION 2.17. Sections 1467.151(a), (b), and (c), Insurance Code, are amended to read as follows:

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

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

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

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

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

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

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

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

[~~(2) related to a claim that is the basis of an~~

~~enrollee complaint~~], including:

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

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

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

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

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

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

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

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

ARTICLE 3. CONFORMING AMENDMENTS

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

(6) "Provider network" means a health benefit plan

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

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

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

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

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

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

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

(A) an insurance company;

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

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

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

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

[~~(F)~~] a multiple employer welfare arrangement

that holds a certificate of authority under Chapter 846;

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

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

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

(c) This chapter does not apply to:

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

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

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

(4) a health benefit plan subject to Section 1466.0053.

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

(1) Section 1456.004(c);

(2) Section 1467.001(2);

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

(4) Section 1467.0511;

(5) Sections 1467.053(b) and (c);

(6) Sections 1467.054(b), (c), (f), and (g);

(7) Sections 1467.055(d) and (h);

(8) Section 1467.057;

(9) Section 1467.058;

(10) Section 1467.059; and

(11) Section 1467.151(d).

ARTICLE 4. STUDY

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

Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (a) The department shall, each biennium, conduct a study on the impacts of S.B. No. 1264, Acts of the 86th Legislature, Regular Session, 2019, on Texas consumers and health coverage in this state, including:

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

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

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

provider;

(4) trends and changes in the amounts paid to participating providers;

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

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

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

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

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

(c) The department:

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

(2) may utilize any reliable external resource or

entity to acquire information reasonably necessary to prepare the report required by Subsection (d).

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

ARTICLE 5. TRANSITION AND EFFECTIVE DATE

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

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

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