

By: Whitmire

S.B. No. 1591

A BILL TO BE ENTITLED

AN ACT

relating to prohibited balance billing and an independent dispute resolution program for out-of-network coverage under certain managed care plans; authorizing a fee.

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

SECTION 1. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1275 to read as follows:

CHAPTER 1275. ENROLLEE RESPONSIBILITY FOR COVERED OUT-OF-NETWORK SERVICES

Sec. 1275.0001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible for coverage under a health benefit plan.

(2) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that provides benefits for health care services. The term does not include:

(A) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(B) the child health plan program operated under Chapter 62, Health and Safety Code;

(C) Medicare benefits; or

(D) benefits designated as excepted benefits

1 under 42 U.S.C. Section 300gg-91(c).

2 (3) "Health benefit plan issuer" means an entity  
3 authorized to engage in business under this code or another  
4 insurance law of this state that issues or offers to issue a health  
5 benefit plan in this state, including:

6 (A) an insurance company;

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

9 (C) a health maintenance organization operating  
10 under Chapter 843; and

11 (D) a stipulated premium company operating under  
12 Chapter 884.

13 (4) "Health care facility" means a hospital, emergency  
14 clinic, outpatient clinic, birthing center, ambulatory surgical  
15 center, or other facility licensed to provide health care services.

16 (5) "Health care practitioner" means an individual who  
17 is licensed to provide and provides health care services.

18 (6) "Health care provider" means a health care  
19 practitioner or health care facility.

20 (7) "Managed care plan" means a health benefit plan  
21 under which health care services are provided to enrollees through  
22 contracts with health care providers and that requires enrollees to  
23 use participating providers or that provides a different level of  
24 coverage for enrollees who use participating providers. The term  
25 includes a health benefit plan issued by:

26 (A) a health maintenance organization;

27 (B) a preferred provider benefit plan issuer; or

1           (C) any other health benefit plan issuer.

2           (8) "Out-of-network provider" means a health care  
3 provider who is not a participating provider.

4           (9) "Participating provider" means a health care  
5 provider, including a preferred provider, who has contracted with a  
6 health benefit plan issuer to provide services to enrollees.

7           (10) "Usual, customary, and reasonable rate" has the  
8 meaning assigned by Section 1467.201.

9           Sec. 1275.0002. APPLICABILITY OF CHAPTER. This chapter  
10 applies only with respect to a managed care plan.

11           Sec. 1275.0003. CERTAIN PLANS EXCLUDED. This chapter does  
12 not apply to a service covered by a health benefit plan subject to  
13 Subchapter B, Chapter 1467.

14           Sec. 1275.0004. BALANCE BILLING PROHIBITED. (a) A health  
15 benefit plan issuer shall pay for a covered service performed for an  
16 enrollee under the health benefit plan by an out-of-network  
17 provider at the usual, customary, and reasonable rate or at an  
18 agreed rate.

19           (b) An out-of-network provider may not bill an enrollee in,  
20 and the enrollee has no financial responsibility for, an amount  
21 greater than the enrollee's responsibility under the enrollee's  
22 managed care plan, including an applicable copayment, coinsurance,  
23 or deductible.

24           SECTION 2. Chapter 1467, Insurance Code, is amended by  
25 adding Subchapter E to read as follows:

26           SUBCHAPTER E. INDEPENDENT DISPUTE RESOLUTION PROGRAM

27           Sec. 1467.201. DEFINITIONS. In this subchapter:

1           (1) "Health benefit plan" means an individual, group,  
2 blanket, or franchise insurance policy or insurance agreement, a  
3 group hospital service contract, or an individual or group evidence  
4 of coverage or similar coverage document that provides benefits for  
5 health care services. The term does not include:

6                   (A) the state Medicaid program, including the  
7 Medicaid managed care program operated under Chapter 533,  
8 Government Code;

9                   (B) the child health plan program operated under  
10 Chapter 62, Health and Safety Code;

11                   (C) Medicare benefits; or

12                   (D) benefits designated as excepted benefits  
13 under 42 U.S.C. Section 300gg-91(c).

14           (2) "Health benefit plan issuer" means an entity  
15 authorized to engage in business under this code or another  
16 insurance law of this state that issues or offers to issue a health  
17 benefit plan in this state, including:

18                   (A) an insurance company;

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

21                   (C) a health maintenance organization operating  
22 under Chapter 843; and

23                   (D) a stipulated premium company operating under  
24 Chapter 884.

25           (3) "Health care facility" means a hospital, emergency  
26 clinic, outpatient clinic, birthing center, ambulatory surgical  
27 center, or other facility licensed to provide health care services.

1           (4) "Health care provider" means a health care  
2 practitioner or health care facility.

3           (5) "Managed care plan" means a health benefit plan  
4 under which health care services are provided to enrollees through  
5 contracts with health care providers and that requires enrollees to  
6 use participating providers or that provides a different level of  
7 coverage for enrollees who use participating providers. The term  
8 includes a health benefit plan issued by:

9                   (A) a health maintenance organization;

10                   (B) a preferred provider benefit plan issuer; or

11                   (C) any other health benefit plan issuer.

12           (6) "Out-of-network provider" means a health care  
13 provider who is not a participating provider.

14           (7) "Participating provider" means a health care  
15 provider who has contracted with a health benefit plan issuer to  
16 provide services to enrollees.

17           (8) "Usual, customary, and reasonable rate" means the  
18 80th percentile of all charges for a particular health care service  
19 performed by a health care provider in the same or similar specialty  
20 and provided in the same geographical area as reported in a  
21 benchmarking database described by Section 1467.203.

22           Sec. 1467.202. APPLICABILITY OF SUBCHAPTER. This  
23 subchapter applies only with respect to a managed care plan.

24           Sec. 1467.203. BENCHMARKING DATABASE. (a) The  
25 commissioner shall select a nonprofit organization to maintain a  
26 benchmarking database that contains information necessary to  
27 calculate the usual, customary, and reasonable rate for each

1 geographical area in this state.

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

5 Sec. 1467.204. ESTABLISHMENT AND ADMINISTRATION OF  
6 PROGRAM. (a) The commissioner shall establish and administer an  
7 independent dispute resolution program to resolve disputes over  
8 out-of-network provider charges, including balance billing, in  
9 accordance with this subchapter.

10 (b) The commissioner:

11 (1) shall adopt rules, forms, and procedures necessary  
12 for the implementation and administration of the independent  
13 dispute resolution program;

14 (2) may impose a fee on the parties participating in  
15 the program as necessary to cover the cost of implementation and  
16 administration of the program; and

17 (3) shall maintain a list of qualified reviewers for  
18 the program.

19 Sec. 1467.205. ISSUE TO BE ADDRESSED; BASIS FOR  
20 DETERMINATION. (a) The only issue that an independent reviewer may  
21 determine in a hearing under the independent dispute resolution  
22 program is the reasonable charge for the health care services  
23 provided to the enrollee by an out-of-network provider.

24 (b) The determination must take into account:

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

27 (A) fees paid to the out-of-network provider for

1 the same services rendered by the provider to other enrollees for  
2 which the provider is an out-of-network provider; and

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

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

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

11 (4) the circumstances and complexity of the enrollee's  
12 particular case, including the time and place of the service;

13 (5) individual enrollee characteristics; and

14 (6) the usual, customary, and reasonable rate for the  
15 health care service.

16 Sec. 1467.206. INITIATION OF PROCESS. (a) A health benefit  
17 plan issuer or out-of-network provider may initiate an independent  
18 dispute resolution process in the form and manner provided by  
19 commissioner rule to determine the amount of reimbursement for a  
20 health care service provided by the provider.

21 (b) A party may respond to the claims made by the party  
22 initiating the independent dispute resolution process under  
23 Subsection (a) not later than the 15th day after the date the  
24 process is initiated. If the responding party fails to respond,  
25 that party accepts the claims made by the initiating party.

26 Sec. 1467.207. SELECTION AND APPROVAL OF INDEPENDENT  
27 REVIEWERS. (a) If the parties do not select an independent

1 reviewer by mutual agreement on or before the 30th day after the  
2 date the independent dispute resolution process is initiated, the  
3 commissioner shall select a reviewer from the commissioner's list  
4 of qualified reviewers.

5 (b) To be eligible to serve as an independent reviewer, an  
6 individual must be knowledgeable and experienced in applicable  
7 principles of contract and insurance law and the health care  
8 industry generally.

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

17 (d) The commissioner shall immediately terminate the  
18 approval of an independent reviewer who no longer meets the  
19 requirements under this subchapter and rules adopted under this  
20 subchapter to serve as an independent reviewer.

21 Sec. 1467.208. PROCEDURES. (a) A party to an independent  
22 dispute resolution process may request an oral hearing.

23 (b) If an oral hearing is not requested, the independent  
24 reviewer shall set a date for submission of all information to be  
25 considered by the reviewer.

26 (c) A party to an independent dispute resolution process  
27 shall submit a binding award amount to the independent reviewer.



1        (d) An independent reviewer may make procedural rulings  
2 during an oral hearing.

3        (e) A party may not engage in discovery in connection with  
4 an independent dispute resolution process.

5        Sec. 1467.209. DECISION. (a) Not later than the 10th day  
6 after the date of an oral hearing or the deadline for submission of  
7 information, as applicable, an independent reviewer shall provide  
8 the parties with a written decision in which the reviewer  
9 determines which binding award amount submitted under Section  
10 1467.208 is the closest to the reasonable charge for the services  
11 provided in accordance with Section 1467.205(b).

12        (b) An independent reviewer may not modify the binding award  
13 amount selected under Subsection (a).

14        (c) The decision described by Subsection (a) is binding and  
15 final. The prevailing party may seek enforcement of the decision in  
16 any court of competent jurisdiction.

17        Sec. 1467.210. ATTORNEY'S FEES AND COSTS. Unless otherwise  
18 agreed by the parties to an independent dispute resolution process,  
19 each party shall:

20                (1) bear the party's own attorney's fees and costs; and  
21                (2) equally split the fees and costs of the  
22 independent reviewer.

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

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

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

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

13           SECTION 4. Section [1467.002](#), Insurance Code, is amended to  
14 read as follows:

15           Sec. 1467.002. APPLICABILITY OF CHAPTER.     Except as  
16 provided by Subchapter E, this [~~This~~] chapter applies only to[~~+~~

17           ~~[(1) a preferred provider benefit plan offered by an~~  
18 ~~insurer under Chapter [1301](#), and~~

19           ~~[(2)]~~ an administrator of a health benefit plan, other  
20 than a health maintenance organization plan, under Chapter [1551](#),  
21 [1575](#), or [1579](#).

22           SECTION 5. Section [1467.005](#), Insurance Code, is amended to  
23 read as follows:

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

26           (1) an [~~insurer offering a preferred provider benefit~~  
27 ~~plan or~~] administrator from, at any time, offering a reformed claim

1 settlement; or

2 (2) a facility-based provider or emergency care  
3 provider from, at any time, offering a reformed charge for health  
4 care or medical services or supplies.

5 SECTION 6. Sections 1467.051(a) and (b), Insurance Code,  
6 are amended to read as follows:

7 (a) An enrollee may request mediation of a settlement of an  
8 out-of-network health benefit claim if:

9 (1) the amount for which the enrollee is responsible  
10 to a facility-based provider or emergency care provider, after  
11 copayments, deductibles, and coinsurance, including the amount  
12 unpaid by the administrator [~~or insurer~~], is greater than \$500; and

13 (2) the health benefit claim is for:

14 (A) emergency care; or

15 (B) a health care or medical service or supply  
16 provided by a facility-based provider in a facility that is a  
17 preferred provider or that has a contract with the administrator.

18 (b) Except as provided by Subsections (c) and (d), if an  
19 enrollee requests mediation under this subchapter, the  
20 facility-based provider or emergency care provider, or the  
21 provider's representative, and [~~the insurer or~~] the  
22 administrator [~~, as appropriate,~~] shall participate in the  
23 mediation.

24 SECTION 7. Section 1467.0511, Insurance Code, is amended to  
25 read as follows:

26 Sec. 1467.0511. NOTICE AND INFORMATION PROVIDED TO  
27 ENROLLEE. (a) A bill sent to an enrollee by a facility-based

1 provider or emergency care provider or an explanation of benefits  
2 sent to an enrollee by an [~~insurer or~~] administrator for an  
3 out-of-network health benefit claim eligible for mediation under  
4 this chapter must contain, in not less than 10-point boldface type,  
5 a conspicuous, plain-language explanation of the mediation process  
6 available under this chapter, including information on how to  
7 request mediation and a statement that is substantially similar to  
8 the following:

9 "You may be able to reduce some of your out-of-pocket costs  
10 for an out-of-network medical or health care claim that is eligible  
11 for mediation by contacting the Texas Department of Insurance at  
12 (website) and (phone number)."

13 (b) If an enrollee contacts an [~~insurer,~~] administrator,  
14 facility-based provider, or emergency care provider about a bill  
15 that may be eligible for mediation under this chapter, the  
16 [~~insurer,~~] administrator, facility-based provider, or emergency  
17 care provider is encouraged to:

18 (1) inform the enrollee about mediation under this  
19 chapter; and

20 (2) provide the enrollee with the department's  
21 toll-free telephone number and Internet website address.

22 SECTION 8. Section [1467.052\(c\)](#), Insurance Code, is amended  
23 to read as follows:

24 (c) A person may not act as mediator for a claim settlement  
25 dispute if the person has been employed by, consulted for, or  
26 otherwise had a business relationship with [~~an insurer offering the~~  
27 ~~preferred provider benefit plan or~~] a physician, health care

1 practitioner, or other health care provider during the three years  
2 immediately preceding the request for mediation.

3 SECTION 9. Section 1467.053(d), Insurance Code, is amended  
4 to read as follows:

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

8 SECTION 10. Sections 1467.054(b) and (c), Insurance Code,  
9 are amended to read as follows:

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

- 13 (1) the name of the enrollee requesting mediation;
- 14 (2) a brief description of the claim to be mediated;
- 15 (3) contact information, including a telephone  
16 number, for the requesting enrollee and the enrollee's counsel, if  
17 the enrollee retains counsel;
- 18 (4) the name of the facility-based provider or  
19 emergency care provider and name of the [~~insurer or~~] administrator;  
20 and
- 21 (5) any other information the commissioner may require  
22 by rule.

23 (c) On receipt of a request for mediation, the department  
24 shall notify the facility-based provider or emergency care provider  
25 and [~~insurer or~~] administrator of the request.

26 SECTION 11. Section 1467.055(i), Insurance Code, is amended  
27 to read as follows:

1 (i) A health care or medical service or supply provided by a  
2 facility-based provider or emergency care provider may not be  
3 summarily disallowed. This subsection does not require an [~~insurer~~  
4 ~~or~~] administrator to pay for an uncovered service or supply.

5 SECTION 12. Sections 1467.056(a), (b), and (d), Insurance  
6 Code, are amended to read as follows:

7 (a) In a mediation under this chapter, the parties shall:

8 (1) evaluate whether:

9 (A) the amount charged by the facility-based  
10 provider or emergency care provider for the health care or medical  
11 service or supply is excessive; and

12 (B) the amount paid by the [~~insurer~~~~or~~]  
13 administrator represents the usual and customary rate for the  
14 health care or medical service or supply or is unreasonably low; and

15 (2) as a result of the amounts described by  
16 Subdivision (1), determine the amount, after copayments,  
17 deductibles, and coinsurance are applied, for which an enrollee is  
18 responsible to the facility-based provider or emergency care  
19 provider.

20 (b) The facility-based provider or emergency care provider  
21 may present information regarding the amount charged for the health  
22 care or medical service or supply. The [~~insurer~~~~or~~] administrator  
23 may present information regarding the amount paid by the [~~insurer~~  
24 ~~or~~] administrator.

25 (d) The goal of the mediation is to reach an agreement among  
26 the enrollee, the facility-based provider or emergency care  
27 provider, and the [~~insurer~~~~or~~] administrator[~~, as applicable,~~] as

1 to the amount paid by the [~~insurer or~~] administrator to the  
2 facility-based provider or emergency care provider, the amount  
3 charged by the facility-based provider or emergency care provider,  
4 and the amount paid to the facility-based provider or emergency  
5 care provider by the enrollee.

6 SECTION 13. Section 1467.058, Insurance Code, is amended to  
7 read as follows:

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

14 SECTION 14. Section 1467.151(b), Insurance Code, is amended  
15 to read as follows:

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

18 (1) on each complaint filed that concerns a claim or  
19 mediation subject to this chapter; and

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

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

24 (B) the type and specialty, if any, of the  
25 facility-based provider or emergency care provider who provided the  
26 out-of-network service;

27 (C) the county and metropolitan area in which the

1 health care or medical service or supply was provided;

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

4 (E) any other information about:

5 (i) the ~~[insurer or]~~ administrator that the  
6 commissioner by rule requires; or

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

10 SECTION 15. The changes in law made by this Act apply only  
11 to a health benefit plan delivered, issued for delivery, or renewed  
12 on or after January 1, 2020. A health benefit plan delivered,  
13 issued for delivery, or renewed before January 1, 2020, is governed  
14 by the law as it existed immediately before the effective date of  
15 this Act, and that law is continued in effect for that purpose.

16 SECTION 16. This Act takes effect September 1, 2019.