House Bill 1742
Senate Amendments
Section-by-Section Analysis

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SECTION 1. Section 1467.001, Insurance Code, is amended by amending Subdivisions (4), (5), and (7) and adding Subdivisions (4-b) and (4-c) to read as follows: (4) "Facility-based provider" means a physician, health care practitioner, or other health care provider who provides health care [~~or medical~~] services to patients of a facility. (4-b) "Health care services" has the meaning assigned by Section 562.002. (4-c) "Laboratory" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made. (5) "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the insurer offering a preferred provider benefit plan or the administrator and a laboratory, facility-based provider, or emergency care provider or the laboratory's or provider's representative to settle a health benefit claim of an enrollee. (7) "Party" means an insurer offering a preferred provider benefit plan, an administrator, or a laboratory, facility-based provider, or emergency care provider or the laboratory's or provider's representative who participates in a mediation conducted under this chapter. The enrollee is also considered a party to the mediation.	SECTION 1. Same as House version.	
SECTION 2. Section 1467.005, Insurance Code, is amended to read as follows: Sec. 1467.005. REFORM. This chapter may not be construed to prohibit: (1) an insurer offering a preferred provider benefit plan or administrator from, at any time, offering a reformed claim settlement; or	SECTION 2. Same as House version.	

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(2) a laboratory, facility-based provider, or emergency care provider from, at any time, offering a reformed charge for health care [~~or medical~~] services [~~or supplies~~].		
SECTION 3. Section 1467.051, Insurance Code, is amended to read as follows: Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION; EXCEPTION. (a) An enrollee may request mediation of a settlement of an out-of-network health benefit claim if: (1) the amount for which the enrollee is responsible to a laboratory, facility-based provider, or emergency care provider, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $500; and (2) the health benefit claim is for: (A) emergency care; [~~or~~] (B) a health care [~~or medical~~] service [~~or supply~~] provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator; or (C) a laboratory service, if: (i) the specimen evaluated by the laboratory is collected: (a) at the office of a health care practitioner who is a preferred provider or has a contract with the administrator; or (b) at a facility that is a preferred provider or that has a contract with the administrator; and (ii) the laboratory is an out-of-network laboratory. (b) Except as provided by Subsections (c) and (d), if an enrollee requests mediation under this subchapter, the laboratory, facility-based provider, or emergency care	SECTION 3. Same as House version.	

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provider, or the laboratory's or provider's representative, and the insurer or the administrator, as appropriate, shall participate in the mediation. (c) Except in the case of an emergency and if requested by the enrollee, a laboratory or facility-based provider shall, before providing a health care [~~or medical~~] service [~~or supply~~], provide a complete disclosure to an enrollee that: (1) explains that the laboratory or facility-based provider does not have a contract with the enrollee's health benefit plan; (2) discloses projected amounts for which the enrollee may be responsible; and (3) discloses the circumstances under which the enrollee would be responsible for those amounts. (d) A laboratory or facility-based provider who makes a disclosure under Subsection (c) and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under this subchapter if the amount billed is less than or equal to the maximum amount projected in the disclosure.		
SECTION 4. Section 1467.0511, Insurance Code, is amended to read as follows: Sec. 1467.0511. NOTICE AND INFORMATION PROVIDED TO ENROLLEE. (a) A bill sent to an enrollee by a laboratory, facility-based provider, or emergency care provider or an explanation of benefits sent to an enrollee by an insurer or administrator for an out-of-network health benefit claim eligible for mediation under this chapter must contain, in not less than 10-point boldface type, a conspicuous, plain-language explanation of the mediation	SECTION 4. Same as House version.	

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process available under this chapter, including information on how to request mediation and a statement that is substantially similar to the following: "You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at (website) and (phone number)." (b) If an enrollee contacts an insurer, administrator, laboratory, facility-based provider, or emergency care provider about a bill that may be eligible for mediation under this chapter, the insurer, administrator, laboratory, facility-based provider, or emergency care provider is encouraged to: (1) inform the enrollee about mediation under this chapter; and (2) provide the enrollee with the department's toll-free telephone number and Internet website address.		
SECTION 5. Section 1467.052(c), Insurance Code, is amended to read as follows: (c) A person may not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with an insurer offering the preferred provider benefit plan or a physician, laboratory, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.	SECTION 5. Same as House version.	
SECTION 6. Section 1467.053(d), Insurance Code, is amended to read as follows:	SECTION 6. Same as House version.	

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(d) The mediator's fees shall be split evenly and paid by the insurer or administrator and the laboratory, facility-based provider, or emergency care provider.		
SECTION 7. Sections 1467.054(b), (c), and (e), Insurance Code, are amended to read as follows: (b) A request for mandatory mediation must be provided to the department on a form prescribed by the commissioner and must include: (1) the name of the enrollee requesting mediation; (2) a brief description of the claim to be mediated; (3) contact information, including a telephone number, for the requesting enrollee and the enrollee's counsel, if the enrollee retains counsel; (4) the name of the laboratory, facility-based provider, or emergency care provider and name of the insurer or administrator; and (5) any other information the commissioner may require by rule. (c) On receipt of a request for mediation, the department shall notify the laboratory, facility-based provider, or emergency care provider and insurer or administrator of the request. (e) A dispute to be mediated under this chapter that does not settle as a result of a teleconference conducted under Subsection (d) must be conducted in the county in which the health care [~~or medical~~] services were rendered.	SECTION 7. Same as House version.	
SECTION 8. Sections 1467.055(d), (h), and (i), Insurance Code, are amended to read as follows:	SECTION 8. Same as House version.	

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(d) If the enrollee is participating in the mediation in person, at the beginning of the mediation the mediator shall inform the enrollee that if the enrollee is not satisfied with the mediated agreement, the enrollee may file a complaint with: (1) the Texas Medical Board or other appropriate regulatory agency against the laboratory, facility-based provider, or emergency care provider for improper billing; and (2) the department for unfair claim settlement practices. (h) On receipt of notice from the department that an enrollee has made a request for mediation that meets the requirements of this chapter, the laboratory, facility-based provider, or emergency care provider may not pursue any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and coinsurance before the earlier of: (1) the date the mediation is completed; or (2) the date the request to mediate is withdrawn. (i) A health care [~~or medical~~] service [~~or supply~~] provided by a laboratory, facility-based provider, or emergency care provider may not be summarily disallowed. This subsection does not require an insurer or administrator to pay for an uncovered service [~~or supply~~].		
SECTION 9. Sections 1467.056(a), (b), and (d), Insurance Code, are amended to read as follows: (a) In a mediation under this chapter, the parties shall: (1) evaluate whether: (A) the amount charged by the laboratory, facility-based provider, or emergency care provider for the health care [~~or medical~~] service [~~or supply~~] is excessive; and	SECTION 9. Same as House version.	

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(B) the amount paid by the 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 laboratory, facility-based provider, or emergency care provider. (b) The laboratory, facility-based provider, or emergency care provider may present information regarding the amount charged for the health care [~~or medical~~] service [~~or supply~~]. The insurer or administrator may present information regarding the amount paid by the insurer or administrator. (d) The goal of the mediation is to reach an agreement among the enrollee, the laboratory, facility-based provider, or emergency care provider, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the laboratory, facility-based provider, or emergency care provider, the amount charged by the laboratory, facility-based provider, or emergency care provider, and the amount paid to the laboratory, facility-based provider, or emergency care provider by the enrollee.		
SECTION 10. Section 1467.058, Insurance Code, is amended to read as follows: Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral is made under Section 1467.057, the laboratory, facility-based provider, or emergency care provider and the insurer or administrator may elect to continue the mediation to further determine their responsibilities. Continuation of	SECTION 10. Same as House version.	

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mediation under this section does not affect the amount of the billed charge to the enrollee.		
SECTION 11. Section 1467.059, Insurance Code, is amended to read as follows: Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall prepare a confidential mediation agreement and order that states: (1) the total amount for which the enrollee will be responsible to the <u>laboratory,</u> facility-based provider<u>,</u> or emergency care provider, after copayments, deductibles, and coinsurance; and (2) any agreement reached by the parties under Section 1467.058.	SECTION 11. Same as House version.	
SECTION 12. Sections 1467.151(a), (b), and (d), 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 <u>services</u> [~~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;	SECTION 12. Same as House version.	

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(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 or mediation subject to this chapter; and
(2) related to a claim that is the basis of an enrollee complaint, including:
(A) the type of services that gave rise to the dispute;
(B) the type and specialty, if any, of the laboratory, facility-based provider, or emergency care provider who provided the out-of-network service;
(C) the county and metropolitan area in which the health care [~~or medical~~] service [~~or supply~~] was provided;
(D) whether the health care [~~or medical~~] service [~~or supply~~] was for emergency care; and
(E) any other information about:
(i) the insurer or administrator that the commissioner by rule requires; or
(ii) the laboratory, facility-based provider, or emergency care provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.
(d) A laboratory, facility-based provider, or emergency care provider who fails to provide a disclosure under Section 1467.051 or 1467.0511 is not subject to discipline by the Texas Medical Board or other appropriate regulatory agency

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for that failure and a cause of action is not created by a failure to disclose as required by Section 1467.051 or 1467.0511.		
SECTION 13. The changes in law made by this Act apply only to a claim for health care services provided on or after January 1, 2020. A claim for health care services provided before January 1, 2020, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 13. The changes in law made by this Act apply only to a claim for health care services provided on or after September 1, 2019. A claim for health care services provided before September 1, 2019, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	
No equivalent provision.	SECTION 14. This Act takes effect only if none of the following bills proposed by the 86th Legislature, Regular Session, 2019, or similar legislation of the 86th Legislature, Regular Session, 2019, are enacted and become law: (1) H.B. 2967, relating to prohibited balance billing and an independent dispute resolution program for out-of-network coverage under certain managed care plans; (2) H.B. 3933, relating to consumer protections against billing and limitations on information reported by consumer reporting agencies; (3) S.B. 1264, relating to consumer protections against certain medical and health care billing by certain out-of-network providers; or (4) S.B. 1591, relating to prohibited balance billing and an independent dispute resolution program for out-of-network coverage under certain managed care plans.	
SECTION 14. This Act takes effect September 1, 2019.	SECTION 15. Same as House version.	