Amend **HB 3924** (senate committee report) as follows:

(1) In SECTION 2 of the bill, strike added Section 1682.007, Insurance Code (page 2, line 51, through page 3, line 3).

(2) Add the following appropriately numbered SECTION to the bill and renumber subsequent SECTIONS of the bill accordingly:

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

CHAPTER 1275. BALANCE BILLING PROHIBITIONS AND OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION FOR CERTAIN PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1275.001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual enrolled in a health benefit plan to which this chapter applies.

(2) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document.

Sec. 1275.002. APPLICABILITY OF CHAPTER. This chapter applies to a health benefit plan offered by a nonprofit agricultural organization under Chapter 1682.

Sec. 1275.003. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a health benefit plan to which this chapter applies shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1275.051, 1275.052, or 1275.053, as applicable;

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

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

(b) The administrator shall provide the explanation of

benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1275.051, 1275.052, or 1275.053, as applicable.

Sec. 1275.004. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION. Chapter 1467 applies to a health benefit plan to which this chapter applies, and the administrator of a health benefit plan to which this chapter applies is an administrator for purposes of that chapter.

SUBCHAPTER B. PAYMENTS FOR CERTAIN SERVICES; BALANCE BILLING PROHIBITIONS

Sec. 1275.051. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a health benefit plan to which this chapter applies shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) For emergency care subject to this section or a supply related to that care, 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, and deductible under the enrollee's health benefit plan that:

(1) is based on:

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

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

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

Sec. 1275.052. OUT-OF-NETWORK FACILITY-BASED PROVIDER PAYMENTS. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a health benefit plan to which this chapter applies shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider 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. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

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

(1) is based on:

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

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

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

(d) 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. 1275.053. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), the administrator of a health benefit plan to which this chapter applies shall pay for a covered health care or medical service performed for or a covered 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 at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

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

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

(1) is based on:

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

(B) if applicable, the modified amount as determined under the administrator's internal appeal process; and

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

(d) 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.