AN ACT

relating to health benefits offered by certain nonprofit agricultural organizations.

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. 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.

SECTION 2. The heading to Subtitle K, Title 8, Insurance Code, is amended to read as follows:

SUBTITLE K. CERTAIN BENEFITS AND ARRANGEMENTS THAT ARE NOT INSURANCE [~~HEALTH CARE SHARING MINISTRIES~~]

SECTION 3. Subtitle K, Title 8, Insurance Code, is amended by adding Chapter 1682 to read as follows:

CHAPTER 1682. HEALTH BENEFITS PROVIDED BY CERTAIN NONPROFIT AGRICULTURAL ORGANIZATIONS

Sec. 1682.001. DEFINITIONS. In this chapter:

(1) "Nonprofit agricultural organization" means an organization that:

(A) is exempt from taxation under Section 501(a), Internal Revenue Code of 1986, as an organization described by Section 501(c)(5) of that code;

(B) is domiciled in this state;

(C) was in existence prior to 1940;

(D) is composed of members who are residents of at least 98 percent of the counties in this state;

(E) collects annual dues from its members; and

(F) was created to promote and develop the most profitable and desirable system of agriculture and the most wholesome and satisfactory conditions of rural life in accordance with its articles of organization and bylaws.

(2) "Nonprofit agricultural organization health benefits" means health benefits:

(A) sponsored by a nonprofit agricultural organization or an affiliate of the organization;

(B) offered only to:

(i) members of the nonprofit agricultural organization; and

(ii) family members of members of the nonprofit agricultural organization;

(C) that are not provided through an insurance policy or other product the offering or issuance of which is regulated as the business of insurance in this state; and

(D) that are deemed by the nonprofit agricultural organization to be important in assisting its members to live long and productive lives.

(3) "Preexisting condition" means a condition present before the effective date of an individual's enrollment in nonprofit agricultural organization health benefits.

Sec. 1682.002. NONPROFIT AGRICULTURAL ORGANIZATION HEALTH BENEFITS AUTHORIZED. A nonprofit agricultural organization or an affiliate of the organization may offer in this state nonprofit agricultural organization health benefits.

Sec. 1682.003. WAITING PERIOD FOR PREEXISTING CONDITION. Notwithstanding any other provision of this chapter, a nonprofit agricultural organization that offers nonprofit agricultural organization health benefits may not require a waiting period of more than six months for treatment of a preexisting condition otherwise included in nonprofit agricultural organization health benefits.

Sec. 1682.004. REQUIRED DISCLOSURE BY NONPROFIT AGRICULTURAL ORGANIZATION. (a) A nonprofit agricultural organization that offers nonprofit agricultural organization health benefits must provide to an individual applying for nonprofit agricultural organization health benefits written notice that the benefits are not provided through an insurance policy or other product the offering or issuance of which is regulated as the business of insurance in this state.

(b) An individual must sign and return to the nonprofit agricultural organization the notice described by Subsection (a) before the individual may enroll in nonprofit agricultural organization health benefits. The nonprofit agricultural organization must:

(1) maintain a copy of the signed written notice for the duration of the term during which the nonprofit agricultural organization health benefits are provided to the individual; and

(2) at the request of the individual, provide a copy of the written notice to the individual.

Sec. 1682.005. NONPROFIT AGRICULTURAL ORGANIZATION NOT ENGAGED IN BUSINESS OF HEALTH INSURANCE. Notwithstanding any other provision of this code, for the purposes of offering nonprofit agricultural organization health benefits, a nonprofit agricultural organization that acts in accordance with this chapter is not a health insurer and is not engaging in the business of health insurance in this state.

Sec. 1682.006. RISK TRANSFER OR COVERAGE. A nonprofit agricultural organization that offers nonprofit agricultural organization health benefits under this chapter may contract with a company authorized to engage in the business of insurance in this state that is not under common control with the nonprofit agricultural organization to:

(1) transfer to that company all or a portion of the organization's risks arising from nonprofit agricultural organization health benefits offered under this chapter; or

(2) obtain insurance coverage from the company guarantying the nonprofit agricultural organization's obligations arising from nonprofit agricultural organization health benefits offered under this chapter.

SECTION 4. This Act takes effect September 1, 2021.

President of the Senate

Speaker of the House

I certify that H.B. No. 3924 was passed by the House on May 5, 2021, by the following vote: Yeas 106, Nays 39, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 3924 on May 28, 2021, by the following vote: Yeas 104, Nays 42, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 3924 was passed by the Senate, with amendments, on May 22, 2021, by the following vote: Yeas 18, Nays 11.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor