

By: Oliverson

H.B. No. 4115

A BILL TO BE ENTITLED

AN ACT

relating to consumer protections against certain medical and health care billing by out-of-network ground ambulance service providers.

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

SECTION 1. Section 38.004(a), Insurance Code, is amended to read as follows:

(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, and subsequently enacted laws prohibiting an individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, or deductible under the insured's, participant's, or enrollee's managed care plan or imposing a requirement related to that prohibition, 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, ground ambulance services, and facility-based services;

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

(3) trends and changes in network participation by

1 providers of emergency services, laboratory services, diagnostic
2 imaging services, ground ambulance services, and facility-based
3 services by provider type or physician specialty, including whether
4 any terminations were initiated by a health benefit plan issuer,
5 administrator, or provider;

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

8 (5) the number of complaints, completed
9 investigations, and disciplinary sanctions for billing by
10 providers of emergency services, laboratory services, diagnostic
11 imaging services, ground ambulance services, or facility-based
12 services of enrollees for amounts greater than the enrollee's
13 responsibility under an applicable health benefit plan, including
14 applicable copayments, coinsurance, and deductibles;

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

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

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

23 SECTION 2. The heading to Section 1271.158, Insurance Code,
24 is amended to read as follows:

25 Sec. 1271.158. CERTAIN NON-NETWORK ANCILLARY [~~DIAGNOSTIC~~
26 ~~IMAGING PROVIDER OR LABORATORY~~] SERVICE PROVIDERS [~~PROVIDER~~].

27 SECTION 3. Sections 1271.158(a), (b), and (c), Insurance

1 Code, are amended to read as follows:

2 (a) In this section, "diagnostic imaging provider,"
3 [~~provider" and~~] "laboratory service provider," and "ground
4 ambulance service provider" have the meanings assigned by Section
5 1467.001.

6 (b) Except as provided by Subsection (d), a health
7 maintenance organization shall pay for a covered health care
8 service performed by or a covered supply related to that service
9 provided to an enrollee by a non-network diagnostic imaging
10 provider, ~~or~~ laboratory service provider, or ground ambulance
11 service provider at the usual and customary rate or at an agreed
12 rate if the provider performed the service in connection with a
13 health care service performed by a network physician or provider.
14 The health maintenance organization shall make a payment required
15 by this subsection directly to the physician or provider not later
16 than, as applicable:

17 (1) the 30th day after the date the health maintenance
18 organization receives an electronic clean claim as defined by
19 Section 843.336 for those services that includes all information
20 necessary for the health maintenance organization to pay the claim;
21 or

22 (2) the 45th day after the date the health maintenance
23 organization receives a nonelectronic clean claim as defined by
24 Section 843.336 for those services that includes all information
25 necessary for the health maintenance organization to pay the claim.

26 (c) Except as provided by Subsection (d), a non-network
27 diagnostic imaging provider, ~~or~~ laboratory service provider, or

1 ground ambulance service provider or a person asserting a claim as
2 an agent or assignee of the provider may not bill an enrollee
3 receiving a health care service or supply described by Subsection
4 (b) in, and the enrollee does not have financial responsibility
5 for, an amount greater than an applicable copayment, coinsurance,
6 and deductible under the enrollee's health care plan that:

7 (1) is based on:

8 (A) the amount initially determined payable by
9 the health maintenance organization; or

10 (B) if applicable, a modified amount as
11 determined under the health maintenance organization's internal
12 appeal process; and

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

15 SECTION 4. The heading to Section 1301.165, Insurance Code,
16 is amended to read as follows:

17 Sec. 1301.165. CERTAIN OUT-OF-NETWORK ANCILLARY
18 [~~DIAGNOSTIC IMAGING PROVIDER OR LABORATORY~~] SERVICE PROVIDERS
19 [~~PROVIDER~~].

20 SECTION 5. Sections 1301.165(a), (b), and (c), Insurance
21 Code, are amended to read as follows:

22 (a) In this section, "diagnostic imaging provider,"
23 [~~provider" and~~] "laboratory service provider," and "ground
24 ambulance service provider" have the meanings assigned by Section
25 1467.001.

26 (b) Except as provided by Subsection (d), an insurer shall
27 pay for a covered medical care or health care service performed by

1 or a covered supply related to that service provided to an insured
2 by an out-of-network provider who is a diagnostic imaging provider,
3 ~~or~~ laboratory service provider, or ground ambulance service
4 provider at the usual and customary rate or at an agreed rate if the
5 provider performed the service in connection with a medical care or
6 health care service performed by a preferred provider. The insurer
7 shall make a payment required by this subsection directly to the
8 provider not later than, as applicable:

9 (1) the 30th day after the date the insurer receives an
10 electronic clean claim as defined by Section 1301.101 for those
11 services that includes all information necessary for the insurer to
12 pay the claim; or

13 (2) the 45th day after the date the insurer receives a
14 nonelectronic clean claim as defined by Section 1301.101 for those
15 services that includes all information necessary for the insurer to
16 pay the claim.

17 (c) Except as provided by Subsection (d), an out-of-network
18 provider who is a diagnostic imaging provider, ~~or~~ laboratory
19 service provider, or ground ambulance service provider or a person
20 asserting a claim as an agent or assignee of the provider may not
21 bill an insured receiving a medical care or health care service or
22 supply described by Subsection (b) in, and the insured does not have
23 financial responsibility for, an amount greater than an applicable
24 copayment, coinsurance, and deductible under the insured's
25 preferred provider benefit plan that:

26 (1) is based on:

27 (A) the amount initially determined payable by

1 the insurer; or

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

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

6 SECTION 6. The heading to Section 1551.230, Insurance Code,
7 is amended to read as follows:

8 Sec. 1551.230. PAYMENTS TO CERTAIN OUT-OF-NETWORK
9 ANCILLARY [~~DIAGNOSTIC IMAGING PROVIDER OR LABORATORY~~] SERVICE
10 PROVIDERS [~~PROVIDER PAYMENTS~~].

11 SECTION 7. Sections 1551.230(a), (b), and (c), Insurance
12 Code, are amended to read as follows:

13 (a) In this section, "diagnostic imaging provider,"
14 [~~provider~~ and] "laboratory service provider," and "ground
15 ambulance service provider" have the meanings assigned by Section
16 1467.001.

17 (b) Except as provided by Subsection (d), the administrator
18 of a managed care plan provided under the group benefits program
19 shall pay for a covered health care or medical service performed for
20 or a covered supply related to that service provided to a
21 participant by an out-of-network provider who is a diagnostic
22 imaging provider, [~~or~~] laboratory service provider, or ground
23 ambulance service provider at the usual and customary rate or at an
24 agreed rate if the provider performed the service in connection
25 with a health care or medical service performed by a participating
26 provider. The administrator shall make a payment required by this
27 subsection directly to the provider not later than, as applicable:

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

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

7 (c) Except as provided by Subsection (d), an out-of-network
8 provider who is a diagnostic imaging provider, ~~or~~ laboratory
9 service provider, or ground ambulance service provider or a person
10 asserting a claim as an agent or assignee of the provider may not
11 bill a participant receiving a health care or medical service or
12 supply described by Subsection (b) in, and the participant does not
13 have financial responsibility for, an amount greater than an
14 applicable copayment, coinsurance, and deductible under the
15 participant's managed care plan that:

16 (1) is based on:

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

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

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

23 SECTION 8. The heading to Section 1575.173, Insurance Code,
24 is amended to read as follows:

25 Sec. 1575.173. PAYMENTS TO CERTAIN OUT-OF-NETWORK
26 ANCILLARY [~~DIAGNOSTIC IMAGING PROVIDER OR LABORATORY~~] SERVICE
27 PROVIDERS [~~PROVIDER PAYMENTS~~].

1 SECTION 9. Sections 1575.173(a), (b), and (c), Insurance
2 Code, are amended to read as follows:

3 (a) In this section, "diagnostic imaging provider,"
4 [~~provider" and~~] "laboratory service provider," and "ground
5 ambulance service provider" have the meanings assigned by Section
6 1467.001.

7 (b) Except as provided by Subsection (d), the administrator
8 of a managed care plan provided under the group program shall pay
9 for a covered health care or medical service performed for or a
10 covered supply related to that service provided to an enrollee by an
11 out-of-network provider who is a diagnostic imaging provider, ~~[or]~~
12 laboratory service provider, or ground ambulance service provider
13 at the usual and customary rate or at an agreed rate if the provider
14 performed the service in connection with a health care or medical
15 service performed by a participating provider. The administrator
16 shall make a payment required by this subsection directly to the
17 provider not later than, as applicable:

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

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

24 (c) Except as provided by Subsection (d), an out-of-network
25 provider who is a diagnostic imaging provider, ~~[or]~~ laboratory
26 service provider, or ground ambulance service provider or a person
27 asserting a claim as an agent or assignee of the provider may not

1 bill an enrollee receiving a health care or medical service or
2 supply described by Subsection (b) in, and the enrollee does not
3 have financial responsibility for, an amount greater than an
4 applicable copayment, coinsurance, and deductible under the
5 enrollee's managed care plan that:

6 (1) is based on:

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

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

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

13 SECTION 10. The heading to Section 1579.111, Insurance
14 Code, is amended to read as follows:

15 Sec. 1579.111. PAYMENTS TO CERTAIN OUT-OF-NETWORK
16 ANCILLARY [~~DIAGNOSTIC IMAGING PROVIDER OR LABORATORY~~] SERVICE
17 PROVIDERS [~~PROVIDER PAYMENTS~~].

18 SECTION 11. Sections 1579.111(a), (b), and (c), Insurance
19 Code, are amended to read as follows:

20 (a) In this section, "diagnostic imaging provider,"
21 [~~provider" and~~] "laboratory service provider," and "ground
22 ambulance service provider" have the meanings assigned by Section
23 1467.001.

24 (b) Except as provided by Subsection (d), the administrator
25 of a managed care plan provided under this chapter shall pay for a
26 covered health care or medical service performed for or a covered
27 supply related to that service provided to an enrollee by an

1 out-of-network provider who is a diagnostic imaging provider, ~~[or]~~
2 laboratory service provider, or ground ambulance service provider
3 at the usual and customary rate or at an agreed rate if the provider
4 performed the service in connection with a health care or medical
5 service performed by a participating provider. The administrator
6 shall make a payment required by this subsection directly to the
7 provider not later than, as applicable:

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

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

14 (c) Except as provided by Subsection (d), an out-of-network
15 provider who is a diagnostic imaging provider, ~~[or]~~ laboratory
16 service provider, or ground ambulance service provider or a person
17 asserting a claim as an agent or assignee of the provider may not
18 bill an enrollee receiving a health care or medical service or
19 supply described by Subsection (b) in, and the enrollee does not
20 have financial responsibility for, an amount greater than an
21 applicable copayment, coinsurance, and deductible under the
22 enrollee's managed care plan that:

23 (1) is based on:

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

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

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

3 SECTION 12. Section 1467.001, Insurance Code, is amended by
4 adding Subdivision (3-b) and amending Subdivisions (4) and (6-a) to
5 read as follows:

6 (3-b) [~~(4)~~] "Facility-based provider" means a
7 physician, health care practitioner, or other health care provider
8 who provides health care or medical services to patients of a
9 facility.

10 (4) "Ground ambulance service provider" means a
11 private entity or municipality providing emergency and
12 nonemergency ground ambulance services. The term includes all
13 personnel employed by the private entity or municipality who bill
14 separately for ground ambulance services.

15 (6-a) "Out-of-network provider" means a diagnostic
16 imaging provider, emergency care provider, facility-based
17 provider, [~~or~~] laboratory service provider, or ground ambulance
18 service provider that is not a participating provider for a health
19 benefit plan.

20 SECTION 13. Section 1467.050(a), Insurance Code, is amended
21 to read as follows:

22 (a) This subchapter applies only with respect to a health
23 benefit claim submitted by an out-of-network provider that is a
24 facility or ground ambulance service provider.

25 SECTION 14. Section 1467.051(a), Insurance Code, is amended
26 to read as follows:

27 (a) An out-of-network provider or a health benefit plan

1 issuer or administrator may request mediation of a settlement of an
2 out-of-network health benefit claim through a portal on the
3 department's Internet website if:

4 (1) there is an amount billed by the provider and
5 unpaid by the issuer or administrator after copayments,
6 deductibles, and coinsurance for which an enrollee may not be
7 billed; and

8 (2) the health benefit claim is for:

9 (A) emergency care;

10 (B) an out-of-network laboratory service; ~~[or]~~

11 (C) an out-of-network diagnostic imaging
12 service; or

13 (D) an out-of-network ground ambulance service.

14 SECTION 15. Section 1467.081, Insurance Code, is amended to
15 read as follows:

16 Sec. 1467.081. APPLICABILITY OF SUBCHAPTER. This
17 subchapter applies only with respect to a health benefit claim
18 submitted by an out-of-network provider who is not a facility or
19 ground ambulance service provider.

20 SECTION 16. The changes in law made by this Act apply only
21 to a ground ambulance service provided on or after January 1, 2022.
22 A ground ambulance service provided before January 1, 2022, is
23 governed by the law in effect immediately before the effective date
24 of this Act, and that law is continued in effect for that purpose.

25 SECTION 17. This Act takes effect September 1, 2021.