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

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

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

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

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

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

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

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

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

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

Code, are amended to read as follows:

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

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a covered health care service performed by or a covered supply related to that service provided to an enrollee by a non-network diagnostic imaging provider, [~~or~~] laboratory service provider, or ground ambulance 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 service performed by a network physician or provider. The health maintenance organization shall make a payment required by this subsection directly to the physician or provider not later than, as applicable:

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

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

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

ground ambulance 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 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 care plan that:

(1) is based on:

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

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

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

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

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

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

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

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

or a covered supply related to that service provided to an insured by an out-of-network provider who is a diagnostic imaging provider, [~~or~~] laboratory service provider, or ground ambulance service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a medical care or health care service performed by a preferred provider. The insurer 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 insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer 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 ground ambulance service provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by

the insurer; or

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

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

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

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

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

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

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under the group benefits program shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to a participant by an out-of-network provider who is a diagnostic imaging provider, [~~or~~] laboratory service provider, or ground ambulance 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 ground ambulance service provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant receiving a health care or medical service or supply described by Subsection (b) in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care 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.

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

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

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

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

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under the group program 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, or ground ambulance 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 ground ambulance 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 managed care 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.

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

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

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

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

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under this chapter 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, or ground ambulance 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 ground ambulance 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 managed care 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.

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

(3-b) [~~(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) "Ground ambulance service provider" means a private entity or municipality providing emergency and nonemergency ground ambulance services. The term includes all personnel employed by the private entity or municipality who bill separately for ground ambulance services.

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

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

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

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

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

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

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

(2) the health benefit claim is for:

(A) emergency care;

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

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

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

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

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

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

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