88R23921 JES-F

By:  Bonnen H.B. No. 5186

Substitute the following for H.B. No. 5186:

By:  Capriglione C.S.H.B. No. 5186

A BILL TO BE ENTITLED

AN ACT

relating to the establishment of the state health benefit plan reimbursement review board and the reimbursement for health care services or supplies provided under certain state-funded health benefit plans.

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

SECTION 1.  Subtitle C, Title 3, Government Code, is amended by adding Chapter 331 to read as follows:

CHAPTER 331. STATE HEALTH BENEFIT PLAN REIMBURSEMENT REVIEW BOARD

Sec. 331.001.  DEFINITIONS. In this chapter:

(1)  "Board" means the state health benefit plan reimbursement review board.

(2)  "Enrollee" means an individual entitled to health benefit coverage under a state health benefit plan.

(3)  "Facility" means:

(A)  a hospital;

(B)  an ambulatory surgical center licensed under Chapter 243, Health and Safety Code;

(C)  a birthing center; or

(D)  a freestanding emergency medical care facility, as defined by Section 254.001, Health and Safety Code, including a freestanding emergency medical care facility that is exempt from the licensing requirements of Chapter 254, Health and Safety Code, under Section 254.052(8), Health and Safety Code.

(4)  "State health benefit plan" means a health benefit plan provided under Chapter 1551, 1575, 1579, or 1601, Insurance Code.

Sec. 331.002.  ESTABLISHMENT; PURPOSE. The state health benefit plan reimbursement review board is established for the purpose of controlling present and future cost growth for state health benefit plans while maintaining access for enrollees to high-quality health care services and supplies.

Sec. 331.003.  MEMBERSHIP. (a) The board consists of:

(1)  the lieutenant governor;

(2)  the speaker of the house of representatives;

(3)  the chair of the senate finance committee;

(4)  the chair of the house appropriations committee;

(5)  three members of the senate appointed by the lieutenant governor; and

(6)  three members of the house appointed by the speaker.

(b)  The lieutenant governor and the speaker of the house of representatives are joint chairs of the board.

Sec. 331.004.  QUORUM; MEETINGS. (a) A majority of the members of the board from each house constitutes a quorum to transact business. If a quorum is present, the board may act on any matter that is within its jurisdiction by a majority vote.

(b)  The board shall meet as often as necessary to perform the board's duties. Meetings may be held at any time at the request of either of the joint chairs of the board.

(c)  The board shall meet in Austin, except that if a majority of the members of the board from each house agree, the board may meet in any location determined by the board.

(d)  As an exception to Chapter 551 and other law, if a meeting is located in Austin and the joint chairs of the board are physically present at the meeting, then any number of the other members of the board may attend the meeting by use of telephone conference call, video conference call, or other similar telecommunication device. This subsection applies for purposes of constituting a quorum, for purposes of voting, and for any other purpose allowing a member of the board to otherwise fully participate in any meeting of the board. This subsection applies without exception with regard to the subject of the meeting or topics considered by the members.

(e)  A meeting held by use of telephone conference call, video conference call, or other similar telecommunication device:

(1)  is subject to the notice requirements applicable to other meetings;

(2)  must specify in the notice of the meeting the location in Austin of the meeting at which the joint chairs will be physically present;

(3)  must be open to the public and shall be audible to the public at the location in Austin specified in the notice of the meeting as the location of the meeting at which the joint chairs will be physically present; and

(4)  must provide two-way audio communication between all members of the board attending the meeting during the entire meeting, and if the two-way audio communication link with any member attending the meeting is disrupted at any time, the meeting may not continue until the two-way audio communication link is reestablished.

Sec. 331.005.  DUTY TO ADOPT REIMBURSEMENT STRUCTURE. The board shall adopt a provider reimbursement structure, regardless of methodology, that each state health benefit plan will use to determine reimbursement to a facility for a health care service or supply, determined by provider type and class and according to whether the facility is an in-network or out-of-network facility. The board may not adopt a reimbursement structure that is in excess of the aggregated provider reimbursement, regardless of methodology, reported by participating state health benefit plans under Section 331.006 for that health care service or supply.

Sec. 331.006.  REPORTS BY STATE HEALTH BENEFIT PLANS. (a) Each state health benefit plan shall submit to the board in the form and manner prescribed by the board a report that includes:

(1)  information on reimbursements and costs for applicable provider types and classes paid by that plan during the preceding plan year;

(2)  recommendations to the board regarding the provider reimbursement structure to be adopted by the board; and

(3)  a summary of public comments received by the plan on the recommendations provided to the board under Subdivision (2).

(b)  Each state health benefit plan shall, before submitting the report required under Subsection (a), allow for public comment on the plan's recommendations to be submitted under that subsection.

Sec. 331.007.  REIMBURSEMENT STRUCTURE REPORT. (a) The board shall analyze the reports submitted under Section 331.006, including the recommendations provided, and issue a report on the reimbursement structure for state health benefit plans. The report issued by the board must:

(1)  establish a provider reimbursement structure, regardless of methodology, in accordance with Section 331.005 that provides for reimbursement that a facility that provides health care services or supplies to an enrollee under a state health benefit plan will receive for those health care services or supplies and specify any other requirements or limitations related to reimbursement;

(2)  be made publicly available on an Internet website; and

(3)  specify that the reimbursement structure in the report is applicable to each state health benefit plan for each plan year beginning after the date the report is issued until the plan year beginning after the date a later report is issued under this subsection.

(b)  The reimbursement structure adopted by the board's report under Subsection (a) is applicable to a state health benefit plan for each plan year beginning after the date the report is issued until the plan year beginning after the date a later report is issued under Subsection (a).

SECTION 2.  Subchapter A, Chapter 1551, Insurance Code, is amended by adding Section 1551.016 to read as follows:

Sec. 1551.016.  REIMBURSEMENT STRUCTURE FOR FACILITIES. (a) In this section:

(1)  "Facility" has the meaning assigned by Section 331.001, Government Code.

(2)  "Review board" means the state health benefit plan reimbursement review board established under Chapter 331, Government Code.

(b)  Notwithstanding any other law or a provision of a contract to the contrary, and subject to limitations imposed by the General Appropriations Act, a facility that bills the group benefits program, an administering firm, or a health benefit plan provided under this chapter, or a designee of the program, firm, or plan, for a health care service or supply provided to a plan enrollee must be reimbursed for the health care service or supply in accordance with the reimbursement structure adopted for the service or supply by the review board for the applicable plan year.

(c)  A facility that receives reimbursement for a health care service or supply as provided by Subsection (b) must consider that reimbursement as payment in full for the service or supply. Except as provided by this subsection, the facility may not charge an enrollee to recover from the enrollee the balance of the facility's fee for a service or supply received by the enrollee from the facility that is not fully reimbursed under Subsection (b). The facility may charge the enrollee an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan.

(d)  A facility may not discriminate against an enrollee or the group benefits program based on the limitation on reimbursement under Subsection (b) by:

(1)  refusing to provide health care services or supplies to the enrollee; or

(2)  providing health care services or supplies of a lower quality to the enrollee than those the facility provides to similar patients who are not enrolled in a health benefit plan under this chapter.

SECTION 3.  Subchapter A, Chapter 1575, Insurance Code, is amended by adding Section 1575.011 to read as follows:

Sec. 1575.011.  REIMBURSEMENT STRUCTURE FOR FACILITIES. (a) In this section:

(1)  "Facility" has the meaning assigned by Section 331.001, Government Code.

(2)  "Review board" means the state health benefit plan reimbursement review board established under Chapter 331, Government Code.

(b)  Notwithstanding any other law or a provision of a contract to the contrary, and subject to limitations imposed by the General Appropriations Act, a facility that bills the group program, an administrator of a health benefit plan provided under this chapter, or a health benefit plan provided under this chapter, or a designee of the program, administrator, or plan, for a health care service or supply provided to a plan enrollee must be reimbursed for the health care service or supply in accordance with the reimbursement structure adopted for the service or supply by the review board for the applicable plan year.

(c)  A facility that receives reimbursement for a health care service or supply as provided by Subsection (b) must consider that reimbursement as payment in full for the service or supply. Except as provided by this subsection, the facility may not charge an enrollee to recover from the enrollee the balance of the facility's fee for a service or supply received by the enrollee from the facility that is not fully reimbursed under Subsection (b). The facility may charge the enrollee an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan.

(d)  A facility may not discriminate against an enrollee or the group program based on the limitation on reimbursement under Subsection (b) by:

(1)  refusing to provide health care services or supplies to the enrollee; or

(2)  providing health care services or supplies of a lower quality to the enrollee than those the facility provides to similar patients who are not enrolled in a health benefit plan under this chapter.

SECTION 4.  Subchapter A, Chapter 1579, Insurance Code, is amended by adding Section 1579.011 to read as follows:

Sec. 1579.011.  REIMBURSEMENT STRUCTURE FOR FACILITIES. (a) In this section:

(1)  "Facility" has the meaning assigned by Section 331.001, Government Code.

(2)  "Review board" means the state health benefit plan reimbursement review board established under Chapter 331, Government Code.

(b)  Notwithstanding any other law or a provision of a contract to the contrary, and subject to limitations imposed by the General Appropriations Act, a facility that bills the program, an administering firm, or a health coverage plan provided under this chapter, or a designee of the program, firm, or plan, for a health care service or supply provided to a plan enrollee must be reimbursed for the health care service or supply in accordance with the reimbursement structure adopted for the service or supply by the review board for the applicable plan year.

(c)  A facility that receives reimbursement for a health care service or supply as provided by Subsection (b) must consider that reimbursement as payment in full for the service or supply. Except as provided by this subsection, the facility may not charge an enrollee to recover from the enrollee the balance of the facility's fee for a service or supply received by the enrollee from the facility that is not fully reimbursed under Subsection (b). The facility may charge the enrollee an applicable copayment, coinsurance, or deductible under the enrollee's health coverage plan.

(d)  A facility may not discriminate against an enrollee or the program based on the limitation on reimbursement under Subsection (b) by:

(1)  refusing to provide health care services or supplies to the enrollee; or

(2)  providing health care services or supplies of a lower quality to the enrollee than those the facility provides to similar patients who are not enrolled in a health coverage plan under this chapter.

SECTION 5.  Subchapter A, Chapter 1601, Insurance Code, is amended by adding Section 1601.012 to read as follows:

Sec. 1601.012.  REIMBURSEMENT STRUCTURE FOR FACILITIES. (a) In this section:

(1)  "Facility" has the meaning assigned by Section 331.001, Government Code.

(2)  "Review board" means the state health benefit plan reimbursement review board established under Chapter 331, Government Code.

(b)  Notwithstanding any other law or a provision of a contract to the contrary, and subject to limitations imposed by the General Appropriations Act, a facility that bills the uniform program, an administering carrier, or a health benefit plan provided under this chapter, or a designee of the program, carrier, or plan, for a health care service or supply provided to a plan enrollee must be reimbursed for the health care service or supply in accordance with the reimbursement structure adopted for the service or supply by the review board for the applicable plan year.

(c)  A facility that receives reimbursement for a health care service or supply as provided by Subsection (b) must consider that reimbursement as payment in full for the service or supply. Except as provided by this subsection, the facility may not charge an enrollee to recover from the enrollee the balance of the facility's fee for a service or supply received by the enrollee from the facility that is not fully reimbursed under Subsection (b). The facility may charge the enrollee an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan.

(d)  A facility may not discriminate against an enrollee or the uniform program based on the limitation on reimbursement under Subsection (b) by:

(1)  refusing to provide health care services or supplies to the enrollee; or

(2)  providing health care services or supplies of a lower quality to the enrollee than those the facility provides to similar patients who are not enrolled in a health benefit plan under this chapter.

SECTION 6.  The changes in law made by this Act apply only to:

(1)  a plan year beginning on or after September 1, 2024; and

(2)  a contract entered into or renewed on or after September 1, 2023.

SECTION 7.  This Act takes effect September 1, 2023.