BILL ANALYSIS

C.S.S.B. 1264
By: Hancock
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

There are concerns that consumers who receive surprise medical bills face unnecessary hurdles in addressing those bills under the existing mediation system. C.S.S.B. 1264 aims to address these concerns by making certain changes to the current mediation process, establishing an arbitration process, expanding the types of plans that are eligible for mediation, and prohibiting providers from sending surprise balance bills to consumers.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance in SECTIONS 1.01, 2.05, 2.10, 2.15, and 2.17 of this bill and to the Texas Medical Board in SECTION 2.17 of this bill and to any applicable regulatory agency in SECTIONS 1.01 and 2.17 of this bill.

ANALYSIS

C.S.S.B. 1264 amends the Insurance Code to require certain health benefit plans that provide coverage for a health care or medical service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider or who is a diagnostic imaging provider or laboratory service provider, as applicable, to provide the coverage 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 or performed the service in connection with a health care service performed by a participating provider, as applicable. The bill exempts from these requirements a nonemergency health care or medical service:

- 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
- for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:
    - explains that the provider does not have a contract with the enrollee's health benefit plan;
    - discloses projected amounts for which the enrollee may be responsible; and
    - discloses the circumstances under which the enrollee would be responsible for those amounts.

The bill requires a health benefit plan that provides coverage for emergency care performed for or a supply related to that care provided to an enrollee by an out-of-network provider to provide the coverage at the usual and customary rate or at an agreed rate. The bill establishes the usual

and customary rate for a health benefit plan issued under the Texas Employees Group Benefits Act, the Texas Public School Retired Employees Group Benefits Act, or the Texas School Employees Uniform Group Health Coverage Act as the relevant allowable amount described by the applicable master benefit plan document or policy.

C.S.S.B. 1264 requires a health maintenance organization (HMO), insurer, or administrator to act on a clean claim related to a health care or medical service or supply required to be covered under the bill's provisions in accordance with statutory provisions relating to the deadline for action on a clean claim as if the out-of-network provider is a participating physician or provider and as if the administrator is an insurer, as applicable.

C.S.S.B. 1264 requires a health benefit plan issuer or administrator to provide written notice in an explanation of benefits provided to the enrollee and the out-of-network provider in connection with a health care service or supply that is subject to the required coverages under the bill's provisions. The bill sets out the required contents of the notice. The bill prohibits an out-of-network provider or a person asserting a claim as an agent or assignee of the provider, for a health care service or supply required to be covered under the bill's provisions, from billing an enrollee an amount greater than an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan that:

- is based on the amount initially determined payable by the health benefit plan issuer or administrator, or if applicable, a modified amount as determined under the issuer's or administrator's internal dispute resolution process; and
- is not based on any additional amount determined to be owed to the provider under provisions relating to out-of-network claim dispute resolution.

The bill expressly holds harmless an enrollee for financial responsibility for that amount.

C.S.S.B. 1264 authorizes the attorney general to bring a civil action in the name of the state to enjoin an individual or entity from a violation if the attorney general receives a referral from the appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating the bill's provisions relating to balance billing prohibitions and to recover reasonable fees, costs, and expenses incurred in bringing the action if the attorney general prevails in the action. The bill requires an appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in Texas to take disciplinary action against such an individual or entity that violates the prohibition against balance billing under the bill's provisions. The bill authorizes such a regulatory agency to adopt rules as necessary to implement this requirement and exempts such a rule from statutory provisions relating to requirements for a rule increasing costs to regulated persons.

C.S.S.B. 1264 applies provisions relating to out-of-network claim dispute resolution to a health benefit plan offered by an HMO and an exclusive provider benefit plan offered by an insurer. The bill removes the chief administrative law judge from the entities required to adopt rules as necessary to implement their respective powers and duties under provisions relating to out-of-network claim dispute resolution. The bill exempts rules adopted under provisions to out-of-network claim dispute resolution from statutory provisions relating to requirements for a rule increasing costs to regulated persons. The bill clarifies the entities that provisions relating to out-of-network claim dispute resolutions may not be construed to prohibit from offering a reformed claim settlement or charge for health care or medical services or supplies. For purposes of provisions relating to out-of-network claim dispute resolution, the bill defines "out-of-network provider" as a diagnostic imaging provider, emergency care provider, facility-based provider, or laboratory service provider that is not a participating provider for a health benefit plan. The bill defines "arbitration" as a process in which an impartial arbiter issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim. The bill revises the definition of "party" to exclude an enrollee from consideration as a party to mediation and otherwise to mean

a health benefit plan issuer offering a health benefit plan, an administrator, or an out-of-network provider or the provider's representative who participates in a mediation or arbitration conducted under those provisions. In addition, the bill defines "diagnostic imaging provider," "diagnostic imaging service," and "laboratory service provider," and revises the definitions for "enrollee" and "mediation" to conform to the changes in law made by the bill.

C.S.S.B. 1264 requires the commissioner of insurance to select an organization to maintain a benchmarking database that contains information necessary to calculate, with respect to a health care or medical service or supply, for each geographical area in Texas the following:

- the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and
- the 50th percentile of rates paid to participating providers who are not facilities.

The bill prohibits the commissioner from selecting an organization that is financially affiliated with a health benefit plan issuer.

C.S.S.B. 1264 sets out provisions relating to mandatory mediation with respect to a health benefit claim submitted by an out-of-network provider that is a licensed ambulatory surgical center, a licensed birthing center, a licensed hospital, or a certain freestanding emergency medical care facility. The bill requires the commissioner to take the following actions:

- establish and administer a mediation program to resolve disputes over out-of-network provider charges; and
- adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program, including the establishment of a portal on the Texas Department of Insurance (TDI) website through which a request for mediation may be submitted and to maintain a list of qualified mediators for the program.

The bill revises provisions relating to availability of mandatory mediation to authorize an out-of-network provider, health benefit plan issuer, or administrator to request mediation of a settlement of an out-of-network health benefit claim through the portal on the TDI website if 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 the claim is for emergency care, an out-of-network laboratory service, or out-of-network diagnostic imaging service. The bill requires the out-of-network provider or the provider's representative and the health benefit plan issuer or the administrator, as appropriate, to participate in the mediation.

C.S.S.B. 1264 changes from the chief administrative law judge to the commissioner the person who approves a dispute resolution organization that conducts the required training in dispute resolution techniques and requires the commissioner to immediately terminate the approval of a mediator who no longer meets applicable requirements and rules adopted under provisions relating to mandatory mediation for out-of-network facilities to serve as a mediator. The bill requires the party requesting mediation to notify the commissioner if the parties to the mediation do not select a mediator by mutual agreement on or before the 30th day after the mediation is requested and requires the commissioner to select a mediator from the commissioner's list of approved mediators. The bill provides for the mediator's fees to be split evenly and paid by the parties. The bill requires the person who requests the mediation to provide written notice on the date the mediation is requested in the form and manner provided by commissioner rule to TDI and each other party.

C.S.S.B. 1264 establishes that an out-of-network provider has a right to a reasonable payment from an enrollee's health benefit plan for covered services and supplies provided to the enrollee and for which the provider has not been fully reimbursed. The bill authorizes either party to a mediation for which there is no agreement, not later than the 45th day after the date the mediator's report concerning the mediation is provided to TDI, to file a civil action to determine the amount due to an out-of-network provider, but prohibits a party from bringing a civil action

before the conclusion of the mediation process. The bill sets a deadline by which the mediator must report to the commissioner and the Texas Medical Board or other appropriate regulatory agency the names of the parties to the mediation and whether the parties reached an agreement.

C.S.S.B. 1264 sets out provisions relating to mandatory binding arbitration with respect to a health benefit claim submitted by an out-of-network provider who is not a licensed ambulatory surgical center, a licensed birthing center, a licensed hospital, or a certain freestanding emergency medical care facility and requires the commissioner to establish and administer an arbitration program to resolve disputes over such out-of-network provider charges. The bill requires the commissioner to adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on the TDI website through which a request for arbitration may be submitted and to maintain a list of qualified arbitrators for the program. The bill establishes that the only issue that an arbitrator may determine is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider. The bill sets out the issues the determination is required to take into account.

C.S.S.B. 1264 authorizes such an out-of-network provider or the health benefit plan issuer or administrator, not later than the 90th day after the date the out-of-network provider receives the initial payment for a health care or medical service or supply, to request arbitration of a settlement of an out-of-network health benefit claim through a portal on the TDI website if there is a charge 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 the health benefit claim is for certain care or services. The bill sets out the following provisions:

- requires the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, to participate in the arbitration;
- requires the person who requested the arbitration to provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to TDI and each other party;
- requires all parties to participate in an informal settlement teleconference not later than the 30th day after the date on which the arbitration is requested and requires the health benefit plan issuer or administrator, as applicable, to make a reasonable effort to arrange the teleconference;
- requires the commissioner to adopt rules providing requirements for submitting arbitration in one proceeding and sets out certain requirement for the rules;
- prohibits an out-of-network provider, health benefit plan issuer, or administrator from filing suit for an out-of-network claim until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

The bill excepts such an arbitration from Civil Practice and Remedies Code provisions relating to alternate methods of dispute resolution. The bill provides for the selection and approval of the arbitrator and requires the commissioner to immediately terminate the approval of an arbitrator who no longer meets applicable requirements to serve as an arbitrator. The bill sets out certain procedures for the arbitration, including prohibiting a party from engaging in discovery in connection with the arbitration, prohibiting an arbitrator from determining whether a health benefit plan covers a particular health care or medical service or supply, and requiring parties to evenly split and pay the arbitrator’s fees and expenses.

C.S.S.B. 1264 requires an arbitrator, not later than the 75th day after the date the arbitration is requested, to provide the parties with a written decision in which the arbitrator:

- determines whether the billed charge or initial payment by the issuer or administrator is the closest reasonable amount for the services or supplies determined in a certain manner, provided that if the out-of-network provider elects to participate in the issuer's or administrator's internal appeal process before arbitration:

    - the provider may revise the billed charge to correct a billing error before the completion of the appeal process; and
    - the health benefit plan issuer or administrator may increase the initial payment under the appeal process; and
- selects the billed charge or initial payment as the binding award amount.

The bill prohibits an arbitrator from modifying the binding award amount and establishes that the arbitrator's decision is binding. The bill requires:

- the arbitrator to provide written notice in the form and manner prescribed by commissioner rule of the reasonable amount for the services or supplies and the binding award amount; and
- the parties, if the parties settle before a decision, to provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement.

The bill requires TDI to maintain a record of such notices.

C.S.S.B. 1264 authorizes a party not satisfied with the decision, not later than the 45th day after the date of an arbitrator's decision, to file an action to determine the payment due to an out-of-network provider and requires a court, in such an action, to determine whether the arbitrator's decision is proper based on a substantial evidence standard of review. The bill requires the health benefit plan issuer or administrator, not later than the 10th day after the arbitrator's decision or a court's determination in such an action, to pay to an out-of-network provider any additional amount necessary to satisfy the binding award or the court's determination, as applicable.

C.S.S.B. 1264 expands provisions relating to bad faith participation in mediation and penalties for such to include participation in arbitration as provided by the bill. The bill includes failing to participate in the informal settlement teleconference or an arbitration, failing to provide information to an arbitrator, and failing to designate a representative participating in the arbitration with full authority to enter into any agreement among the acts that constitute bad faith participation in resolving an out-of-network claim dispute.

C.S.S.B. 1264 revises requirements for rules adopted by the commissioner and the Texas Medical Board or other regulatory agency, as appropriate, that regulate the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim and revises the information that TDI and the Texas Medical Board or other appropriate regulatory agency is required to maintain. The bill provides for the applicability of its provisions.

C.S.S.B. 1264 requires TDI, each biennium, to conduct a study on the impacts of the bill's provisions on Texas consumers and health coverage in Texas. The bill sets out the issues included in the study. The bill requires TDI, in conducting the study, to collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration. The bill requires TDI to collect data quarterly from a health benefit plan issuer or administrator to conduct the study and authorizes TDI to use any reliable external resource or entity to acquire information reasonably necessary to prepare the report. The bill requires TDI, not later than December 1 of each even-numbered year, to prepare and submit a written report on the results of the study, including the findings of TDI, to the legislature.

C.S.S.B. 1264 applies only to a health care or medical service or supply provided on or after January 1, 2020. The bill establishes that TDI, the Employees Retirement System of Texas, the Teacher Retirement System of Texas, and any other state agency subject to the bill's provisions are required to implement a provision of the bill only if the legislature appropriates money specifically for that purpose and that those agencies may, but are not required to, implement a provision of the bill using other appropriations available for that purpose.

C.S.S.B. 1264 repeals the following provisions of the Insurance Code:

- Section 1456.004(c)
- Section 1467.001(2)
- Sections 1467.051(c) and (d)
- Section 1467.0511
- Sections 1467.053(b) and (c)
- Sections 1467.054(b), (c), (f) and (g)
- Section 1467.055(d) and (h)
- Section 1467.057
- Section 1467.058
- Section 1467.059
- Section 1467.151(d)

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 1264 may differ from the engrossed in minor or nonsubstantive ways, the following summarizes the substantial differences between the engrossed and committee substitute versions of the bill.

The substitute does not include provisions requiring an HMO, insurer, or administrator of a managed care plan under the Texas Employees Group Benefits Act, the Texas Public School Retired Employees Group Benefits Act, or the Texas School Employees Uniform Group Health Coverage Act to provide certain written notice in an explanation of benefits provided to an enrollee and the physician or provider of required emergency care coverage, non-network or out-of-network facility-based provider coverage, and a non-network or out-of-network diagnostic imaging provider or laboratory service provider coverage, as applicable, including a statement of certain billing prohibitions. The substitute instead includes a requirement for a health benefit plan issuer or administrator to provide certain written notice in an explanation of benefits provided to the enrollee and the out-of-network provider in connection with a health care service or supply that is subject to the required coverages.

The substitute does not include requirements for an HMO, insurer, or an administrator of an applicable managed care plan to pay for emergency care, a health care service or supply related to that service provided to an enrollee by a non-network or out-of-network physician or provider who is a facility-based provider, a non-network or out-of-network diagnostic imaging provider or laboratory service provider, as applicable, at the usual and customary rate or at an agreed rate or requirements for applicable managed care plans to provide out-of-network emergency care coverage, out-of-network facility-based provider coverage, and out-of-network diagnostic imaging provider and laboratory service provider coverage. The substitute instead includes requirements for certain health benefit plans to provide emergency care coverage, coverage for a health care or medical service performed for or a supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider or a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate.

The substitute includes a requirement for an HMO, insurer, and an administrator to act on a clean claim related to a health care or medical service or supply as if the out-of-network provider is a participating physician or provider or preferred provider and as if the administrator is an insurer, as applicable.

The substitute revises provisions relating to an injunction for balance billing and enforcement by a regulatory agency to condition an action brought by the attorney general on a referral from the appropriate regulatory agency and to require, rather than authorize, disciplinary action against a physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider for a violation of the prohibition against balance billing. The substitute includes a provision removing the requirement that the chief administrative law judge adopt rules as necessary to implement the judge's powers and duties under provisions relating to out-of-network claim dispute resolution.

The substitute does not include provisions revising the existing statutory mandatory mediation provisions as mandatory binding arbitration provisions but the substitute includes similar provisions that are applicable instead to the establishment and administration of processes regarding:

- health benefit claims submitted to mandatory mediation that that are exclusive to an out-of-network provider that is an applicable facility; and
- health benefit claims submitted to mandatory binding arbitration that are exclusive to an out-of-network provider that is not an applicable facility.

The substitute does not repeal certain provisions regarding mediation, with respect to mediator qualifications, the appointment of a mediator and certain related fees, request and preliminary procedures for mandatory mediation, the conduct of mediation and confidentiality of communications, certain matters considered in mediation and related agreed resolutions, and a certain report of a mediator. The substitute instead revises and applicably repeals certain of those statutory provisions to reflect the mediation provisions included in the substitute that are applicable to an out-of-network provider that is an applicable facility.

The substitute includes provisions, with respect to an out-of-network provider that is an applicable facility:

- establishing that an out-of-network provider has a right to a reasonable payment from an enrollee's health benefit plan for covered services and supplies provided to the enrollee and for which the provider has not been fully reimbursed;
- authorizing either party to a mediation for which there is no agreement, not later than the 45th day after the date the mediator's report concerning the mediation is provided to TDI, to file a civil action to determine the amount due to an out-of-network provider; and
- prohibiting a party from bringing a civil action before the conclusion of the mediation process.

The substitute revises provisions relating to bad faith participation.

The substitute revises provisions relating to the balance billing prohibition report TDI is required to submit to the legislature concerning a study on the impacts of the bill's provisions.