All Prefiled Amendments for: SB 1264

Oliverson

Amendment	861876

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HOUSE OF REPRESENTATIVES

FLOOR AMENDMENT NO._____ BY: Oliverson

Amend C.S.S.B. No. 1264 (house committee printing) by striking all below the enacting clause and substituting the following:

ARTICLE 1. ELIMINATION OF SURPRISE BILLING FOR CERTAIN HEALTH BENEFIT PLANS

SECTION 1.01. Subtitle G, Title 5, Insurance Code, is amended by adding Chapter 752 to read as follows:

CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

Sec. 752.0001. DEFINITION. In this chapter, "administrator" has the meaning assigned by Section 1467.001.

Sec. 752.0002. INJUNCTION FOR BALANCE BILLING. (a) 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 a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation.

(b) If the attorney general prevails in an action brought under Subsection (a), the attorney general may recover reasonable attorney's fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action.

Sec. 752.0003. ENFORCEMENT BY REGULATORY AGENCY. (a) 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 this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition.

(b) The department may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.

(c) A regulatory agency described by Subsection (a) or the commissioner may adopt rules as necessary to implement this section. Section 2001.0045, Government Code, does not apply to rules adopted under this subsection.

SECTION 1.02. Subchapter A, Chapter 1271, Insurance Code, is amended by adding Section 1271.008 to read as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. (a) A health maintenance organization shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or provider in connection with a health care service or supply provided by a non-network physician or provider. The notice must include:

(1) a statement of the billing prohibition under Section 1271.155, 1271.157, or 1271.158, 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) A health maintenance organization 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 health maintenance organization makes a payment under Section 1271.155, 1271.157, or 1271.158, as applicable.

SECTION 1.03. Section 1271.155, Insurance Code, is amended by amending Subsection (b) and adding Subsections (f) and (g) to read as follows:

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; [~~and~~]

(3) services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d); and

(4) supplies related to a service described by this subsection shall be provided to covered enrollees.

(f) For emergency care subject to this section or a supply related to that care, a health maintenance organization shall make a payment required by Subsection (a) directly to the non-network physician or provider not later than, as applicable:

(1) the 30th day after the date the health maintenance organization receives an electronic claim 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 claim for those services that includes all information necessary for the health maintenance organization to pay the claim.

(g) For emergency care subject to this section or a supply related to that care, a non-network physician or provider or a person asserting a claim as an agent or assignee of the physician or 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 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 physician or provider under Chapter 1467.

SECTION 1.04. Subchapter D, Chapter 1271, Insurance Code, is amended by adding Sections 1271.157 and 1271.158 to read as follows:

Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS.

(a) In this section, "facility-based provider" means a physician or provider who provides health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), a health maintenance organization shall pay for a covered health care service performed for or a covered supply related to that service provided to an enrollee by a non-network physician or 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 network 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 claim 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 claim 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 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 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.

(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 non-network physician or provider providing the service; and

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the physician or 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. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (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), 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 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 claim 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 claim 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 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.

(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 non-network physician or provider providing the service; and

(2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the physician or 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 1.05. Section 1301.0045(b), Insurance Code, is amended to read as follows:

(b) Except as provided by Sections 1301.0052, 1301.0053, [~~and~~] 1301.155, 1301.164, and 1301.165, this chapter may not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

SECTION 1.06. Section 1301.0053, Insurance Code, is amended to read as follows:

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. (a) If an out-of-network [~~a nonpreferred~~] provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall reimburse the out-of-network [~~nonpreferred~~] provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network [~~nonpreferred~~] provider for the provision of the services and any supply related to those services. 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 claim 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 claim for those services that includes all information necessary for the insurer to pay the claim.

(b) 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 insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's exclusive provider benefit plan that:

(1) is based on:

(A) the amount initially determined payable by the insurer; or

(B) if applicable, a 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 1.07. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.010 to read as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. (a) An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable;

(2) the total amount the physician or provider may bill the insured under the insured's preferred provider 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) An insurer 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 insurer makes a payment under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as applicable.

SECTION 1.08. Section 1301.155, Insurance Code, is amended by amending Subsection (b) and adding Subsections (c) and (d) to read as follows:

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate and at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; [~~and~~]

(3) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition; and

(4) supplies related to a service described by this subsection.

(c) For emergency care subject to this section or a supply related to that care, an insurer shall make a payment required by

this section directly to the out-of-network provider not later than, as applicable:

(1) the 30th day after the date the insurer receives an electronic claim 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 claim for those services that includes all information necessary for the insurer to pay the claim.

(d) 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 insured 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, a 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 1.09. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Sections 1301.164 and 1301.165 to read as follows:

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS. (a) In this section, "facility-based provider" means a physician or health care provider who provides medical care or health care services to patients of a health care facility.

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

or a covered supply related to that service provided to an insured 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 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 claim 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 claim 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 facility-based 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, a 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.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an insured 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 insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER. (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), 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 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 claim 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 claim 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 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.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an insured 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 insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

(B) discloses projected amounts for which the insured may be responsible; and

(C) discloses the circumstances under which the insured would be responsible for those amounts.

SECTION 1.10. Section 1551.003, Insurance Code, is amended by adding Subdivision (15) to read as follows:

(15) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan

document or policy.

SECTION 1.11. Subchapter A, Chapter 1551, Insurance Code, is amended by adding Section 1551.015 to read as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group benefits program shall provide written notice in accordance with this section in an explanation of benefits provided to the participant 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 1551.228, 1551.229, or 1551.230, as applicable;

(2) the total amount the physician or provider may bill the participant under the participant's managed care 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 1551.228, 1551.229, or 1551.230, as applicable.

SECTION 1.12. Subchapter E, Chapter 1551, Insurance Code, is amended by adding Sections 1551.228, 1551.229, and 1551.230 to read as follows:

Sec. 1551.228. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under the group benefits program 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 a participant 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, 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. 1551.229. 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 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 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 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, 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 a participant 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 participant that:

(A) explains that the provider does not have a contract with the participant's managed care plan;

(B) discloses projected amounts for which the participant may be responsible; and

(C) discloses the circumstances under which the participant would be responsible for those amounts.

Sec. 1551.230. 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 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 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 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.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that a participant 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 participant that:

(A) explains that the provider does not have a contract with the participant's managed care plan;

(B) discloses projected amounts for which the participant may be responsible; and

(C) discloses the circumstances under which the participant would be responsible for those amounts.

SECTION 1.13. Section 1575.002, Insurance Code, is amended by adding Subdivision (8) to read as follows:

(8) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document or policy.

SECTION 1.14. Subchapter A, Chapter 1575, Insurance Code, is amended by adding Section 1575.009 to read as follows:

Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under the group program 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 1575.171, 1575.172, or 1575.173, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care 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 1575.171, 1575.172, or 1575.173, as applicable.

SECTION 1.15. Subchapter D, Chapter 1575, Insurance Code, is amended by adding Sections 1575.171, 1575.172, and 1575.173 to read as follows:

Sec. 1575.171. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under the group program 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 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.

Sec. 1575.172. 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 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 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 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.

(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 managed care 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. 1575.173. 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 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 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 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.

(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 managed care 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 1.16. Section 1579.002, Insurance Code, is amended by adding Subdivision (8) to read as follows:

(8) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document or policy.

SECTION 1.17. Subchapter A, Chapter 1579, Insurance Code, is amended by adding Section 1579.009 to read as follows:

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter 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 1579.109, 1579.110, or 1579.111, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care 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 1579.109, 1579.110, or 1579.111, as applicable.

SECTION 1.18. Subchapter C, Chapter 1579, Insurance Code, is amended by adding Sections 1579.109, 1579.110, and 1579.111 to read as follows:

Sec. 1579.109. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under this chapter 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 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.

Sec. 1579.110. 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 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 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 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.

(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 managed care 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. 1579.111. 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 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 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 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.

(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 managed care 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.

ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SECTION 2.01. Section 1467.001, Insurance Code, is amended by adding Subdivisions (1-a), (2-c), (2-d), (4-b), and (6-a) and amending Subdivisions (2-a), (2-b), (3), (5), and (7) to read as follows:

(1-a) "Arbitration" means 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.

(2-a) "Diagnostic imaging provider" means a health care provider who performs a diagnostic imaging service on a patient for a fee or interprets imaging produced by a diagnostic imaging service.

(2-b) "Diagnostic imaging service" means magnetic resonance imaging, computed tomography, positron emission tomography, or any hybrid technology that combines any of those imaging modalities.

(2-c) "Emergency care" has the meaning assigned by Section 1301.155.

(2-d) [~~(2-b)~~] "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.

(3) "Enrollee" means an individual who is eligible to receive benefits through a [~~preferred provider benefit plan or a~~] health benefit plan subject to this chapter [~~under Chapter 1551, 1575, or 1579~~].

(4-b) "Laboratory service provider" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a physician who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

(5) "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the health [~~insurer offering a preferred provider~~] benefit plan issuer or the administrator and an out-of-network [~~a facility-based~~] provider [~~or emergency care provider~~] or the provider's representative to settle a health benefit claim of an enrollee.

(6-a) "Out-of-network provider" means 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.

(7) "Party" means a health benefit plan issuer [~~an insurer~~] offering a health [~~a preferred provider~~] benefit plan, an administrator, or an out-of-network [~~a facility-based provider or emergency care~~] provider or the provider's representative who participates in a mediation or arbitration conducted under this chapter. [~~The enrollee is also considered a party to the mediation.~~]

SECTION 2.02. Sections 1467.002, 1467.003, and 1467.005,

Insurance Code, are amended to read as follows:

Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter applies to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843;

(2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and

(3) [~~(2)~~] an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.

Sec. 1467.003. RULES. (a) The commissioner, the Texas Medical Board, and any other appropriate regulatory agency[~~, and the chief administrative law judge~~] shall adopt rules as necessary to implement their respective powers and duties under this chapter.

(b) Section 2001.0045, Government Code, does not apply to a rule adopted under this chapter.

Sec. 1467.005. REFORM. This chapter may not be construed to prohibit:

(1) a health [~~an insurer offering a preferred provider~~] benefit plan issuer or administrator from, at any time, offering a reformed claim settlement; or

(2) an out-of-network [~~a facility-based provider or emergency care~~] provider from, at any time, offering a reformed charge for health care or medical services or supplies.

SECTION 2.03. Subchapter A, Chapter 1467, Insurance Code, is amended by adding Section 1467.006 to read as follows:

Sec. 1467.006. BENCHMARKING DATABASE. (a) In this section, "geozip area" means an area that includes all zip codes with identical first three digits. For purposes of this section, a health care or medical service or supply provided at a location that

does not have a zip code is considered to be provided in the geozip area closest to the location at which the service or supply is provided.

(b) The commissioner shall select an organization to maintain a benchmarking database in accordance with this section. The organization may not:

(1) be affiliated with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider; or

(2) have any other conflict of interest.

(c) The benchmarking database must contain information necessary to calculate, with respect to a health care or medical service or supply, for each geozip area in this state:

(1) the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and

(2) the 50th percentile of rates paid to participating providers who are not facilities.

(d) The commissioner may adopt rules governing the submission of information for the benchmarking database described by Subsection (c).

SECTION 2.04. The heading to Subchapter B, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER B. MANDATORY MEDIATION FOR OUT-OF-NETWORK FACILITIES

SECTION 2.05. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Sections 1467.050 and 1467.0505 to read as follows:

Sec. 1467.050. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider that is a facility.

(b) This subchapter does not apply to a health benefit claim for the professional or technical component of a physician service.

Sec. 1467.0505. ESTABLISHMENT AND ADMINISTRATION OF MEDIATION PROGRAM. (a) The commissioner shall establish and administer a mediation program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program, including the establishment of a portal on the department's Internet website through which a request for mediation under Section 1467.051 may be submitted; and

(2) shall maintain a list of qualified mediators for the program.

SECTION 2.06. The heading to Section 1467.051, Insurance Code, is amended to read as follows:

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION[~~; EXCEPTION~~].

SECTION 2.07. Sections 1467.051(a) and (b), Insurance Code, are amended to read as follows:

(a) An out-of-network provider or a health benefit plan issuer or administrator [~~An enrollee~~] 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 [~~the~~] amount billed by the provider and unpaid by the issuer or administrator [~~for which the enrollee is responsible to a facility-based provider or emergency care provider,~~] after copayments, deductibles, and coinsurance for which an enrollee may not be billed [~~, including the amount unpaid by the administrator or insurer, is greater than $500~~]; and

(2) the health benefit claim is for:

(A) emergency care; [~~or~~]

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

(C) an out-of-network diagnostic imaging service [~~a health care or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator~~].

(b) If a person [~~Except as provided by Subsections (c) and (d), if an enrollee~~] requests mediation under this subchapter, the out-of-network [~~facility-based~~] provider [~~or emergency care provider,~~] or the provider's representative, and the health benefit plan issuer [~~insurer~~] or the administrator, as appropriate, shall participate in the mediation.

SECTION 2.08. Section 1467.052, Insurance Code, is amended by amending Subsections (a) and (c) and adding Subsection (d) to read as follows:

(a) Except as provided by Subsection (b), to qualify for an appointment as a mediator under this subchapter [~~chapter~~] a person must have completed at least 40 classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the commissioner [~~chief administrative law judge~~].

(c) A person may not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with a health [~~an insurer offering the preferred provider~~] benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.

(d) The commissioner shall immediately terminate the approval of a mediator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as

a mediator.

SECTION 2.09. Section 1467.053, Insurance Code, is amended by adding Subsection (b-1) and amending Subsection (d) to read as follows:

(b-1) If the parties do not select a mediator by mutual agreement on or before the 30th day after the date the mediation is requested, the party requesting the mediation shall notify the commissioner, and the commissioner shall select a mediator from the commissioner's list of approved mediators.

(d) The mediator's fees shall be split evenly and paid by the health benefit plan issuer [~~insurer~~] or administrator and the out-of-network [~~facility-based provider or emergency care~~] provider.

SECTION 2.10. Section 1467.054, Insurance Code, is amended by amending Subsections (a) and (d) and adding Subsection (b-1) to read as follows:

(a) An out-of-network provider or a health benefit plan issuer or administrator [~~enrollee~~] may request mandatory mediation under this subchapter [~~chapter~~].

(b-1) The person who requests the mediation shall provide written notice on the date the mediation is requested in the form and manner provided by commissioner rule to:

(1) the department; and

(2) each other party.

(d) In an effort to settle the claim before mediation, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which a person [~~the enrollee~~] submits a request for mediation under this subchapter [~~section~~].

SECTION 2.11. Section 1467.055, Insurance Code, is amended by adding Subsections (c-1) and (k) and amending Subsections (g)

and (i) to read as follows:

(c-1) Information submitted by the parties to the mediator is confidential and not subject to disclosure under Chapter 552, Government Code.

(g) A [~~Except at the request of an enrollee, a~~] mediation shall be held not later than the 180th day after the date of the request for mediation.

(i) A health care or medical service or supply provided by an out-of-network [~~a facility-based~~] provider [~~or emergency care provider~~] may not be summarily disallowed. This subsection does not require a health benefit plan issuer [~~an insurer~~] or administrator to pay for an uncovered service or supply.

(k) On agreement of all parties, any deadline under this subchapter may be extended.

SECTION 2.12. Sections 1467.056(a), (b), and (d), Insurance Code, are amended to read as follows:

(a) In a mediation under this subchapter [~~chapter~~], the parties shall[~~:~~

[~~(1)~~] evaluate whether:

(1) [~~(A)~~] the amount charged by the out-of-network [~~facility-based~~] provider [~~or emergency care provider~~] for the health care or medical service or supply is excessive; and

(2) [~~(B)~~] the amount paid by the health benefit plan issuer [~~insurer~~] or administrator represents the usual and customary rate for the health care or medical service or supply or is unreasonably low[~~; and~~

[~~(2) as a result of the amounts described by Subdivision (1), determine the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is responsible to the facility-based provider or emergency care provider~~].

(b) The out-of-network [~~facility-based~~] provider [~~or emergency care provider~~] may present information regarding the amount charged for the health care or medical service or supply. The health benefit plan issuer [~~insurer~~] or administrator may present information regarding the amount paid by the issuer [~~insurer~~] or administrator.

(d) The goal of the mediation is to reach an agreement between [~~among the enrollee,~~] the out-of-network [~~facility-based~~] provider [~~or emergency care provider,~~] and the health benefit plan issuer [~~insurer~~] or administrator, as applicable, as to the amount paid by the issuer [~~insurer~~] or administrator to the out-of-network [~~facility-based~~] provider and [~~or emergency care provider,~~] the amount charged by the out-of-network [~~facility-based~~] provider [~~or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee~~].

SECTION 2.13. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Section 1467.0575 to read as follows:

Sec. 1467.0575. RIGHT TO FILE ACTION. Not later than the 45th day after the date that the mediator's report is provided to the department under Section 1467.060, either party to a mediation for which there was no agreement may file a civil action to determine the amount due to an out-of-network provider. A party may not bring a civil action before the conclusion of the mediation process under this subchapter.

SECTION 2.14. Section 1467.060, Insurance Code, is amended to read as follows:

Sec. 1467.060. REPORT OF MEDIATOR. Not later than the 45th day after the date the mediation concludes, the [~~The~~] mediator shall report to the commissioner and the Texas Medical Board or other appropriate regulatory agency:

(1) the names of the parties to the mediation; and

(2) whether the parties reached an agreement [~~or the mediator made a referral under Section 1467.057~~].

SECTION 2.15. Chapter 1467, Insurance Code, is amended by adding Subchapter B-1 to read as follows:

SUBCHAPTER B-1. MANDATORY BINDING ARBITRATION FOR OTHER PROVIDERS

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.

Sec. 1467.082. ESTABLISHMENT AND ADMINISTRATION OF ARBITRATION PROGRAM. (a) The commissioner shall establish and administer an arbitration program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on the department's Internet website through which a request for arbitration under Section 1467.084 may be submitted; and

(2) shall maintain a list of qualified arbitrators for the program.

Sec. 1467.083. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) The only issue that an arbitrator may determine under this subchapter is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider.

(b) The determination must take into account:

(1) whether there is a gross disparity between the fee billed by the out-of-network provider and:

(A) fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other

enrollees for which the provider is an out-of-network provider; and

(B) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;

(2) the level of training, education, and experience of the out-of-network provider;

(3) the out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;

(4) the circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply;

(5) individual enrollee characteristics;

(6) the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(8) the history of network contracting between the parties;

(9) historical data for the percentiles described by Subdivisions (6) and (7); and

(10) an offer made during the informal settlement teleconference required under Section 1467.084(d).

Sec. 1467.084. AVAILABILITY OF MANDATORY ARBITRATION. (a) Not later than the 90th day after the date an out-of-network provider receives the initial payment for a health care or medical service or supply, the out-of-network provider or the health

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

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

(2) the health benefit claim is for:

(A) emergency care;

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider;

(C) an out-of-network laboratory service; or

(D) an out-of-network diagnostic imaging service.

(b) If a person requests arbitration under this subchapter, the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the arbitration.

(c) The person who requests the arbitration shall provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to:

(1) the department; and

(2) each other party.

(d) In an effort to settle the claim before arbitration, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which the arbitration is requested. A health benefit plan issuer or administrator, as applicable, shall make a reasonable effort to arrange the teleconference.

(e) The commissioner shall adopt rules providing requirements for submitting multiple claims to arbitration in one

proceeding. The rules must provide that:

(1) the total amount in controversy for multiple claims in one proceeding may not exceed $5,000; and

(2) the multiple claims in one proceeding must be limited to the same out-of-network provider.

Sec. 1467.085. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Notwithstanding Section 1467.004, an out-of-network provider or health benefit plan issuer or administrator may not file suit for an out-of-network claim subject to this chapter until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

(b) An arbitration conducted under this subchapter is not subject to Title 7, Civil Practice and Remedies Code.

Sec. 1467.086. SELECTION AND APPROVAL OF ARBITRATOR. (a) If the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is requested, the party requesting the arbitration shall notify the commissioner, and the commissioner shall select an arbitrator from the commissioner's list of approved arbitrators.

(b) In selecting an arbitrator under this section, the commissioner shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

(c) In approving an individual as an arbitrator, the commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an arbitration. A conflict of interest includes current or recent ownership or employment of the individual or a close family member in any health benefit plan issuer or administrator or physician, health care practitioner, or other health care provider.

(d) The commissioner shall immediately terminate the approval of an arbitrator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as an arbitrator.

Sec. 1467.087. PROCEDURES. (a) The arbitrator shall set a date for submission of all information to be considered by the arbitrator.

(b) A party may not engage in discovery in connection with the arbitration.

(c) On agreement of all parties, any deadline under this subchapter may be extended.

(d) Unless otherwise agreed to by the parties, an arbitrator may not determine whether a health benefit plan covers a particular health care or medical service or supply.

(e) The parties shall evenly split and pay the arbitrator's fees and expenses.

(f) Information submitted by the parties to the arbitrator is confidential and not subject to disclosure under Chapter 552, Government Code.

Sec. 1467.088. DECISION. (a) Not later than the 51st day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed charge or the payment made by the health benefit plan issuer or administrator, as those amounts were last modified during the issuer's or administrator's internal appeal process, if the provider elects to participate, or the informal settlement teleconference required by Section 1467.084(d), as applicable, is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.083(b); and

(2) selects the amount determined to be closest under Subdivision (1) as the binding award amount.

(b) An arbitrator may not modify the binding award amount selected under Subsection (a).

(c) An arbitrator shall 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. If the parties settle before a decision, the parties shall provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement. The department shall maintain a record of notices provided under this subsection.

Sec. 1467.089. EFFECT OF DECISION. (a) An arbitrator's decision under Section 1467.088 is binding.

(b) Not later than the 45th day after the date of an arbitrator's decision under Section 1467.088, a party not satisfied with the decision may file an action to determine the payment due to an out-of-network provider.

(c) In an action filed under Subsection (b), the court shall determine whether the arbitrator's decision is proper based on a substantial evidence standard of review.

(d) Not later than the 30th day after the date of an arbitrator's decision under Section 1467.088, a health benefit plan issuer or administrator shall pay to an out-of-network provider any additional amount necessary to satisfy the binding award.

SECTION 2.16. Subchapter C, Chapter 1467, Insurance Code, is amended to read as follows:

SUBCHAPTER C. BAD FAITH PARTICIPATION [~~MEDIATION~~]

Sec. 1467.101. BAD FAITH. (a) The following conduct constitutes bad faith participation [~~mediation~~] for purposes of this chapter:

(1) failing to participate in the informal settlement

teleconference under Section 1467.084(d) or an arbitration or mediation under this chapter;

(2) failing to provide information the arbitrator or mediator believes is necessary to facilitate a decision or [~~an~~] agreement; or

(3) failing to designate a representative participating in the arbitration or mediation with full authority to enter into any [~~mediated~~] agreement.

(b) Failure to reach an agreement under Subchapter B is not conclusive proof of bad faith participation [~~mediation~~].

Sec. 1467.102. PENALTIES. (a) Bad faith participation or otherwise failing to comply with Subchapter B-1 [~~mediation, by a party other than the enrollee,~~] is grounds for imposition of an administrative penalty by the regulatory agency that issued a license or certificate of authority to the party who committed the violation.

(b) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith participation under Subchapter B [~~mediation~~], the regulatory agency that issued the license or certificate of authority shall impose an administrative penalty.

SECTION 2.17. Sections 1467.151(a), (b), and (c), Insurance Code, are amended to read as follows:

(a) The commissioner and the Texas Medical Board or other regulatory agency, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. The rules adopted under this section must:

(1) distinguish among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed health care or medical care;

(2) develop a form for filing a complaint [~~and~~

~~establish an outreach effort to inform enrollees of the availability of the claims dispute resolution process under this chapter~~]; and

(3) ensure that a complaint is not dismissed without appropriate consideration[~~;~~

[~~(4) ensure that enrollees are informed of the availability of mandatory mediation; and~~

[~~(5) require the administrator to include a notice of the claims dispute resolution process available under this chapter with the explanation of benefits sent to an enrollee~~].

(b) The department and the Texas Medical Board or other appropriate regulatory agency shall maintain information[~~:~~

[~~(1)~~] on each complaint filed that concerns a claim, arbitration, or mediation subject to this chapter[~~; and~~

[~~(2) related to a claim that is the basis of an enrollee complaint~~], including:

(1) [~~(A)~~] the type of services or supplies that gave rise to the dispute;

(2) [~~(B)~~] the type and specialty, if any, of the out-of-network [~~facility-based~~] provider [~~or emergency care provider~~] who provided the out-of-network service or supply;

(3) [~~(C)~~] the county and metropolitan area in which the health care or medical service or supply was provided;

(4) [~~(D)~~] whether the health care or medical service or supply was for emergency care; and

(5) [~~(E)~~] any other information about:

(A) [~~(i)~~] the health benefit plan issuer [~~insurer~~] or administrator that the commissioner by rule requires; or

(B) [~~(ii)~~] the out-of-network [~~facility-based~~] provider [~~or emergency care provider~~] that the Texas Medical Board

or other appropriate regulatory agency by rule requires.

(c) The information collected and maintained [~~by the department and the Texas Medical Board and other appropriate regulatory agencies~~] under Subsection (b) [~~(b)(2)~~] is public information as defined by Section 552.002, Government Code, and may not include personally identifiable information or health care or medical information.

ARTICLE 3. CONFORMING AMENDMENTS

SECTION 3.01. Section 1456.003(a), Insurance Code, is amended to read as follows:

(a) Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:

(1) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network; and

(2) a health care practitioner described by Subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan unless the health care or medical service or supply provided to the enrollee is subject to a law prohibiting balance billing.

SECTION 3.02. Section 1456.006, Insurance Code, is amended to read as follows:

Sec. 1456.006. COMMISSIONER RULES; FORM OF DISCLOSURE. The commissioner by rule may prescribe specific requirements for the disclosure required under Section 1456.003. The form of the disclosure must be substantially as follows:

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE

FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

SECTION 3.03. The following provisions of the Insurance Code are repealed:

(1) Section 1456.004(c);

(2) Section 1467.001(2);

(3) Sections 1467.051(c) and (d);

(4) Section 1467.0511;

(5) Sections 1467.053(b) and (c);

(6) Sections 1467.054(b), (c), (f), and (g);

(7) Sections 1467.055(d) and (h);

(8) Section 1467.057;

(9) Section 1467.058;

(10) Section 1467.059; and

(11) Section 1467.151(d).

ARTICLE 4. STUDY

SECTION 4.01. Subchapter A, Chapter 38, Insurance Code, is amended by adding Section 38.004 to read as follows:

Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (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, 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, and facility-based services;

(2) comparison of the total amount spent on out-of-network emergency services, laboratory services, diagnostic

imaging 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, 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, 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, and facility-based services; and

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

(b) In conducting the study described by Subsection (a), the department shall collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under Chapter 1467.

(c) The department may not publish a particular rate paid to a participating provider in the study described by Subsection (a),

identifying information of a physician or health care provider, or non-aggregated study results. Information described by this subsection is confidential and not subject to disclosure under Chapter 552, Government Code.

(d) The department:

(1) shall collect data quarterly from a health benefit plan issuer or administrator subject to Chapter 1467 to conduct the study required by this section; and

(2) may utilize any reliable external resource or entity to acquire information reasonably necessary to prepare the report required by Subsection (e).

(e) Not later than December 1 of each even-numbered year, the department shall prepare and submit a written report on the results of the study under this section, including the department's findings, to the legislature.

ARTICLE 5. TRANSITION AND EFFECTIVE DATE

SECTION 5.01. The changes in law made by this Act apply only to a health care or medical service or supply provided on or after January 1, 2020. A health care or medical service or supply provided before January 1, 2020, 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 5.02. This Act takes effect September 1, 2019.