

All Prefiled Amendments for: SB 1264

Oliverson

Amendment

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HOUSE OF REPRESENTATIVES

FLOOR AMENDMENT NO. _____

BY: Oliverson

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

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

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

8 CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

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

11 Sec. 752.0002. INJUNCTION FOR BALANCE BILLING. (a) If the
12 attorney general receives a referral from the appropriate
13 regulatory agency indicating that an individual or entity,
14 including a health benefit plan issuer or administrator, has
15 exhibited a pattern of intentionally violating a law that prohibits
16 the individual or entity from billing an insured, participant, or
17 enrollee in an amount greater than an applicable copayment,
18 coinsurance, and deductible under the insured's, participant's, or
19 enrollee's managed care plan or that imposes a requirement related
20 to that prohibition, the attorney general may bring a civil action
21 in the name of the state to enjoin the individual or entity from the
22 violation.

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

27 Sec. 752.0003. ENFORCEMENT BY REGULATORY AGENCY. (a) An
28 appropriate regulatory agency that licenses, certifies, or
29 otherwise authorizes a physician, health care practitioner, health

1 care facility, or other health care provider to practice or operate
2 in this state may take disciplinary action against the physician,
3 practitioner, facility, or provider if the physician,
4 practitioner, facility, or provider violates a law that prohibits
5 the physician, practitioner, facility, or provider from billing an
6 insured, participant, or enrollee in an amount greater than an
7 applicable copayment, coinsurance, and deductible under the
8 insured's, participant's, or enrollee's managed care plan or that
9 imposes a requirement related to that prohibition.

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

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

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

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

27 (1) a statement of the billing prohibition under
28 Section 1271.155, 1271.157, or 1271.158, as applicable;

29 (2) the total amount the physician or provider may
30 bill the enrollee under the enrollee's health benefit plan and an
31 itemization of copayments, coinsurance, deductibles, and other

1 amounts included in that total; and

2 (3) for an explanation of benefits provided to the
3 physician or provider, information required by commissioner rule
4 advising the physician or provider of the availability of mediation
5 or arbitration, as applicable, under Chapter 1467.

6 (b) A health maintenance organization shall provide the
7 explanation of benefits with the notice required by this section to
8 a physician or health care provider not later than the date the
9 health maintenance organization makes a payment under Section
10 1271.155, 1271.157, or 1271.158, as applicable.

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

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

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

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

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

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

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

5 (1) the 30th day after the date the health maintenance
6 organization receives an electronic claim for those services that
7 includes all information necessary for the health maintenance
8 organization to pay the claim; or

9 (2) the 45th day after the date the health maintenance
10 organization receives a nonelectronic claim for those services that
11 includes all information necessary for the health maintenance
12 organization to pay the claim.

13 (g) For emergency care subject to this section or a supply
14 related to that care, a non-network physician or provider or a
15 person asserting a claim as an agent or assignee of the physician or
16 provider may not bill an enrollee in, and the enrollee does not have
17 financial responsibility for, an amount greater than an applicable
18 copayment, coinsurance, and deductible under the enrollee's health
19 care plan that:

20 (1) is based on:

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

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

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

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

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

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

4 (b) Except as provided by Subsection (d), a health
5 maintenance organization shall pay for a covered health care
6 service performed for or a covered supply related to that service
7 provided to an enrollee by a non-network physician or provider who
8 is a facility-based provider at the usual and customary rate or at
9 an agreed rate if the provider performed the service at a health
10 care facility that is a network provider. The health maintenance
11 organization shall make a payment required by this subsection
12 directly to the physician or provider not later than, as
13 applicable:

14 (1) the 30th day after the date the health maintenance
15 organization receives an electronic claim for those services that
16 includes all information necessary for the health maintenance
17 organization to pay the claim; or

18 (2) the 45th day after the date the health maintenance
19 organization receives a nonelectronic claim for those services that
20 includes all information necessary for the health maintenance
21 organization to pay the claim.

22 (c) Except as provided by Subsection (d), a non-network
23 facility-based provider or a person asserting a claim as an agent or
24 assignee of the provider may not bill an enrollee receiving a health
25 care service or supply described by Subsection (b) in, and the
26 enrollee does not have financial responsibility for, an amount
27 greater than an applicable copayment, coinsurance, and deductible
28 under the enrollee's health care plan that:

29 (1) is based on:

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

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

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

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

8 (1) that an enrollee elects to receive in writing in
9 advance of the service with respect to each non-network physician
10 or provider providing the service; and

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

14 (A) explains that the physician or provider does
15 not have a contract with the enrollee's health benefit plan;

16 (B) discloses projected amounts for which the
17 enrollee may be responsible; and

18 (C) discloses the circumstances under which the
19 enrollee would be responsible for those amounts.

20 Sec. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR
21 LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic
22 imaging provider" and "laboratory service provider" have the
23 meanings assigned by Section 1467.001.

24 (b) Except as provided by Subsection (d), a health
25 maintenance organization shall pay for a covered health care
26 service performed by or a covered supply related to that service
27 provided to an enrollee by a non-network diagnostic imaging
28 provider or laboratory service provider at the usual and customary
29 rate or at an agreed rate if the provider performed the service in
30 connection with a health care service performed by a network
31 physician or provider. The health maintenance organization shall

1 make a payment required by this subsection directly to the
2 physician or provider not later than, as applicable:

3 (1) the 30th day after the date the health maintenance
4 organization receives an electronic claim for those services that
5 includes all information necessary for the health maintenance
6 organization to pay the claim; or

7 (2) the 45th day after the date the health maintenance
8 organization receives a nonelectronic claim for those services that
9 includes all information necessary for the health maintenance
10 organization to pay the claim.

11 (c) Except as provided by Subsection (d), a non-network
12 diagnostic imaging provider or laboratory service provider or a
13 person asserting a claim as an agent or assignee of the provider may
14 not bill an enrollee receiving a health care service or supply
15 described by Subsection (b) in, and the enrollee does not have
16 financial responsibility for, an amount greater than an applicable
17 copayment, coinsurance, and deductible under the enrollee's health
18 care plan that:

19 (1) is based on:

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

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

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

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

29 (1) that an enrollee elects to receive in writing in
30 advance of the service with respect to each non-network physician
31 or provider providing the service; and

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

4 (A) explains that the physician or provider does
5 not have a contract with the enrollee's health benefit plan;

6 (B) discloses projected amounts for which the
7 enrollee may be responsible; and

8 (C) discloses the circumstances under which the
9 enrollee would be responsible for those amounts.

10 SECTION 1.05. Section 1301.0045(b), Insurance Code, is
11 amended to read as follows:

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

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

19 Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS:
20 EMERGENCY CARE. (a) If an out-of-network [~~a nonpreferred~~]
21 provider provides emergency care as defined by Section 1301.155 to
22 an enrollee in an exclusive provider benefit plan, the issuer of the
23 plan shall reimburse the out-of-network [~~nonpreferred~~] provider at
24 the usual and customary rate or at a rate agreed to by the issuer and
25 the out-of-network [~~nonpreferred~~] provider for the provision of the
26 services and any supply related to those services. The insurer
27 shall make a payment required by this subsection directly to the
28 provider not later than, as applicable:

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

1 (2) the 45th day after the date the insurer receives a
2 nonelectronic claim for those services that includes all
3 information necessary for the insurer to pay the claim.

4 (b) For emergency care subject to this section or a supply
5 related to that care, an out-of-network provider or a person
6 asserting a claim as an agent or assignee of the provider may not
7 bill an insured in, and the insured does not have financial
8 responsibility for, an amount greater than an applicable copayment,
9 coinsurance, and deductible under the insured's exclusive provider
10 benefit plan that:

11 (1) is based on:

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

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

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

18 SECTION 1.07. Subchapter A, Chapter 1301, Insurance Code,
19 is amended by adding Section 1301.010 to read as follows:

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

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

28 (2) the total amount the physician or provider may
29 bill the insured under the insured's preferred provider benefit
30 plan and an itemization of copayments, coinsurance, deductibles,
31 and other amounts included in that total; and

1 (3) for an explanation of benefits provided to the
2 physician or provider, information required by commissioner rule
3 advising the physician or provider of the availability of mediation
4 or arbitration, as applicable, under Chapter 1467.

5 (b) An insurer shall provide the explanation of benefits
6 with the notice required by this section to a physician or health
7 care provider not later than the date the insurer makes a payment
8 under Section 1301.0053, 1301.155, 1301.164, or 1301.165, as
9 applicable.

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

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

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

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

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

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

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

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

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

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

9 (d) For emergency care subject to this section or a supply
10 related to that care, an out-of-network provider or a person
11 asserting a claim as an agent or assignee of the provider may not
12 bill an insured in, and the insured does not have financial
13 responsibility for, an amount greater than an applicable copayment,
14 coinsurance, and deductible under the insured's preferred provider
15 benefit plan that:

16 (1) is based on:

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

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

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

23 SECTION 1.09. Subchapter D, Chapter 1301, Insurance Code,
24 is amended by adding Sections 1301.164 and 1301.165 to read as
25 follows:

26 Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDERS.

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

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

1 or a covered supply related to that service provided to an insured
2 by an out-of-network provider who is a facility-based provider at
3 the usual and customary rate or at an agreed rate if the provider
4 performed the service at a health care facility that is a preferred
5 provider. The insurer shall make a payment required by this
6 subsection directly to the provider not later than, as applicable:

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

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

13 (c) Except as provided by Subsection (d), an out-of-network
14 provider who is a facility-based provider or a person asserting a
15 claim as an agent or assignee of the provider may not bill an
16 insured receiving a medical care or health care service or supply
17 described by Subsection (b) in, and the insured does not have
18 financial responsibility for, an amount greater than an applicable
19 copayment, coinsurance, and deductible under the insured's
20 preferred provider benefit plan that:

21 (1) is based on:

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

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

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

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

30 (1) that an insured elects to receive in writing in
31 advance of the service with respect to each out-of-network provider

1 providing the service; and

2 (2) for which an out-of-network provider, before
3 providing the service, provides a complete written disclosure to
4 the insured that:

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

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

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

11 Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER
12 OR LABORATORY SERVICE PROVIDER. (a) In this section, "diagnostic
13 imaging provider" and "laboratory service provider" have the
14 meanings assigned by Section 1467.001.

15 (b) Except as provided by Subsection (d), an insurer shall
16 pay for a covered medical care or health care service performed by
17 or a covered supply related to that service provided to an insured
18 by an out-of-network provider who is a diagnostic imaging provider
19 or laboratory service provider at the usual and customary rate or at
20 an agreed rate if the provider performed the service in connection
21 with a medical care or health care service performed by a preferred
22 provider. The insurer shall make a payment required by this
23 subsection directly to the provider not later than, as applicable:

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

27 (2) the 45th day after the date the insurer receives a
28 nonelectronic claim for those services that includes all
29 information necessary for the insurer to pay the claim.

30 (c) Except as provided by Subsection (d), an out-of-network
31 provider who is a diagnostic imaging provider or laboratory service

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

7 (1) is based on:

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

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

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

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

16 (1) that an insured elects to receive in writing in
17 advance of the service with respect to each out-of-network provider
18 providing the service; and

19 (2) for which an out-of-network provider, before
20 providing the service, provides a complete written disclosure to
21 the insured that:

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

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

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

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

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

1 document or policy.

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

4 Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE.

5 (a) The administrator of a managed care plan provided under the
6 group benefits program shall provide written notice in accordance
7 with this section in an explanation of benefits provided to the
8 participant and the physician or health care provider in connection
9 with a health care or medical service or supply provided by an
10 out-of-network provider. The notice must include:

11 (1) a statement of the billing prohibition under
12 Section 1551.228, 1551.229, or 1551.230, as applicable;

13 (2) the total amount the physician or provider may
14 bill the participant under the participant's managed care plan and
15 an itemization of copayments, coinsurance, deductibles, and other
16 amounts included in that total; and

17 (3) for an explanation of benefits provided to the
18 physician or provider, information required by commissioner rule
19 advising the physician or provider of the availability of mediation
20 or arbitration, as applicable, under Chapter 1467.

21 (b) The administrator shall provide the explanation of
22 benefits with the notice required by this section to a physician or
23 health care provider not later than the date the administrator
24 makes a payment under Section 1551.228, 1551.229, or 1551.230, as
25 applicable.

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

29 Sec. 1551.228. EMERGENCY CARE PAYMENTS. (a) In this
30 section, "emergency care" has the meaning assigned by Section
31 1301.155.

1 (b) The administrator of a managed care plan provided under
2 the group benefits program shall pay for covered emergency care
3 performed by or a covered supply related to that care provided by an
4 out-of-network provider at the usual and customary rate or at an
5 agreed rate. The administrator shall make a payment required by
6 this subsection directly to the provider not later than, as
7 applicable:

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

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

14 (c) For emergency care subject to this section or a supply
15 related to that care, an out-of-network provider or a person
16 asserting a claim as an agent or assignee of the provider may not
17 bill a participant in, and the participant does not have financial
18 responsibility for, an amount greater than an applicable copayment,
19 coinsurance, and deductible under the participant's managed care
20 plan that:

21 (1) is based on:

22 (A) the amount initially determined payable by
23 the administrator; or

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

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

28 Sec. 1551.229. OUT-OF-NETWORK FACILITY-BASED PROVIDER
29 PAYMENTS. (a) In this section, "facility-based provider" means a
30 physician or health care provider who provides health care or
31 medical services to patients of a health care facility.

1 (b) Except as provided by Subsection (d), the administrator
2 of a managed care plan provided under the group benefits program
3 shall pay for a covered health care or medical service performed for
4 or a covered supply related to that service provided to a
5 participant by an out-of-network provider who is a facility-based
6 provider at the usual and customary rate or at an agreed rate if the
7 provider performed the service at a health care facility that is a
8 participating provider. The administrator shall make a payment
9 required by this subsection directly to the provider not later
10 than, as applicable:

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

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

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

25 (1) is based on:

26 (A) the amount initially determined payable by
27 the administrator; or

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

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

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

3 (1) that a participant elects to receive in writing in
4 advance of the service with respect to each out-of-network provider
5 providing the service; and

6 (2) for which an out-of-network provider, before
7 providing the service, provides a complete written disclosure to
8 the participant that:

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

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

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

15 Sec. 1551.230. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER
16 OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section,
17 "diagnostic imaging provider" and "laboratory service provider"
18 have the meanings assigned by Section 1467.001.

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

30 (1) the 30th day after the date the administrator
31 receives an electronic claim for those services that includes all

1 information necessary for the administrator to pay the claim; or

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

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

13 (1) is based on:

14 (A) the amount initially determined payable by
15 the administrator; or

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

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

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

22 (1) that a participant elects to receive in writing in
23 advance of the service with respect to each out-of-network provider
24 providing the service; and

25 (2) for which an out-of-network provider, before
26 providing the service, provides a complete written disclosure to
27 the participant that:

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

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

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

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

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

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

10 Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE.

11 (a) The administrator of a managed care plan provided under the
12 group program shall provide written notice in accordance with this
13 section in an explanation of benefits provided to the enrollee and
14 the physician or health care provider in connection with a health
15 care or medical service or supply provided by an out-of-network
16 provider. The notice must include:

17 (1) a statement of the billing prohibition under
18 Section 1575.171, 1575.172, or 1575.173, as applicable;

19 (2) the total amount the physician or provider may
20 bill the enrollee under the enrollee's managed care plan and an
21 itemization of copayments, coinsurance, deductibles, and other
22 amounts included in that total; and

23 (3) for an explanation of benefits provided to the
24 physician or provider, information required by commissioner rule
25 advising the physician or provider of the availability of mediation
26 or arbitration, as applicable, under Chapter 1467.

27 (b) The administrator shall provide the explanation of
28 benefits with the notice required by this section to a physician or
29 health care provider not later than the date the administrator
30 makes a payment under Section 1575.171, 1575.172, or 1575.173, as
31 applicable.

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

4 Sec. 1575.171. EMERGENCY CARE PAYMENTS. (a) In this
5 section, "emergency care" has the meaning assigned by Section
6 1301.155.

7 (b) The administrator of a managed care plan provided under
8 the group program shall pay for covered emergency care performed by
9 or a covered supply related to that care provided by an
10 out-of-network provider at the usual and customary rate or at an
11 agreed rate. The administrator shall make a payment required by
12 this subsection directly to the provider not later than, as
13 applicable:

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

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

20 (c) For emergency care subject to this section or a supply
21 related to that care, an out-of-network provider or a person
22 asserting a claim as an agent or assignee of the provider may not
23 bill an enrollee in, and the enrollee does not have financial
24 responsibility for, an amount greater than an applicable copayment,
25 coinsurance, and deductible under the enrollee's managed care plan
26 that:

27 (1) is based on:

28 (A) the amount initially determined payable by
29 the administrator; or

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

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

3 Sec. 1575.172. OUT-OF-NETWORK FACILITY-BASED PROVIDER
4 PAYMENTS. (a) In this section, "facility-based provider" means a
5 physician or health care provider who provides health care or
6 medical services to patients of a health care facility.

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

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

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

23 (c) Except as provided by Subsection (d), an out-of-network
24 provider who is a facility-based provider or a person asserting a
25 claim as an agent or assignee of the provider may not bill an
26 enrollee receiving a health care or medical service or supply
27 described by Subsection (b) in, and the enrollee does not have
28 financial responsibility for, an amount greater than an applicable
29 copayment, coinsurance, and deductible under the enrollee's
30 managed care plan that:

31 (1) is based on:

1 (A) the amount initially determined payable by
2 the administrator; or

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

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

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

9 (1) that an enrollee elects to receive in writing in
10 advance of the service with respect to each out-of-network provider
11 providing the service; and

12 (2) for which an out-of-network provider, before
13 providing the service, provides a complete written disclosure to
14 the enrollee that:

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

17 (B) discloses projected amounts for which the
18 enrollee may be responsible; and

19 (C) discloses the circumstances under which the
20 enrollee would be responsible for those amounts.

21 Sec. 1575.173. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER
22 OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section,
23 "diagnostic imaging provider" and "laboratory service provider"
24 have the meanings assigned by Section 1467.001.

25 (b) Except as provided by Subsection (d), the administrator
26 of a managed care plan provided under the group program shall pay
27 for a covered health care or medical service performed for or a
28 covered supply related to that service provided to an enrollee by an
29 out-of-network provider who is a diagnostic imaging provider or
30 laboratory service provider at the usual and customary rate or at an
31 agreed rate if the provider performed the service in connection

1 with a health care or medical service performed by a participating
2 provider. The administrator shall make a payment required by this
3 subsection directly to the provider not later than, as applicable:

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

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

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

18 (1) is based on:

19 (A) the amount initially determined payable by
20 the administrator; or

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

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

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

27 (1) that an enrollee elects to receive in writing in
28 advance of the service with respect to each out-of-network provider
29 providing the service; and

30 (2) for which an out-of-network provider, before
31 providing the service, provides a complete written disclosure to

1 the enrollee that:

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

4 (B) discloses projected amounts for which the
5 enrollee may be responsible; and

6 (C) discloses the circumstances under which the
7 enrollee would be responsible for those amounts.

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

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

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

15 Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE.

16 (a) The administrator of a managed care plan provided under this
17 chapter shall provide written notice in accordance with this
18 section in an explanation of benefits provided to the enrollee and
19 the physician or health care provider in connection with a health
20 care or medical service or supply provided by an out-of-network
21 provider. The notice must include:

22 (1) a statement of the billing prohibition under
23 Section 1579.109, 1579.110, or 1579.111, as applicable;

24 (2) the total amount the physician or provider may
25 bill the enrollee under the enrollee's managed care plan and an
26 itemization of copayments, coinsurance, deductibles, and other
27 amounts included in that total; and

28 (3) for an explanation of benefits provided to the
29 physician or provider, information required by commissioner rule
30 advising the physician or provider of the availability of mediation
31 or arbitration, as applicable, under Chapter 1467.

1 (b) The administrator shall provide the explanation of
2 benefits with the notice required by this section to a physician or
3 health care provider not later than the date the administrator
4 makes a payment under Section 1579.109, 1579.110, or 1579.111, as
5 applicable.

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

9 Sec. 1579.109. EMERGENCY CARE PAYMENTS. (a) In this
10 section, "emergency care" has the meaning assigned by Section
11 1301.155.

12 (b) The administrator of a managed care plan provided under
13 this chapter shall pay for covered emergency care performed by or a
14 covered supply related to that care provided by an out-of-network
15 provider at the usual and customary rate or at an agreed rate. The
16 administrator shall make a payment required by this subsection
17 directly to the provider not later than, as applicable:

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

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

24 (c) For emergency care subject to this section or a supply
25 related to that care, an out-of-network provider or a person
26 asserting a claim as an agent or assignee of the provider may not
27 bill an enrollee in, and the enrollee does not have financial
28 responsibility for, an amount greater than an applicable copayment,
29 coinsurance, and deductible under the enrollee's managed care plan
30 that:

31 (1) is based on:

1 (A) the amount initially determined payable by
2 the administrator; or

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

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

7 Sec. 1579.110. OUT-OF-NETWORK FACILITY-BASED PROVIDER
8 PAYMENTS. (a) In this section, "facility-based provider" means a
9 physician or health care provider who provides health care or
10 medical services to patients of a health care facility.

11 (b) Except as provided by Subsection (d), the administrator
12 of a managed care plan provided under this chapter shall pay for a
13 covered health care or medical service performed for or a covered
14 supply related to that service provided to an enrollee by an
15 out-of-network provider who is a facility-based provider at the
16 usual and customary rate or at an agreed rate if the provider
17 performed the service at a health care facility that is a
18 participating provider. The administrator shall make a payment
19 required by this subsection directly to the provider not later
20 than, as applicable:

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

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

27 (c) Except as provided by Subsection (d), an out-of-network
28 provider who is a facility-based provider or a person asserting a
29 claim as an agent or assignee of the provider may not bill an
30 enrollee receiving a health care or medical service or supply
31 described by Subsection (b) in, and the enrollee does not have

1 financial responsibility for, an amount greater than an applicable
2 copayment, coinsurance, and deductible under the enrollee's
3 managed care plan that:

4 (1) is based on:

5 (A) the amount initially determined payable by
6 the administrator; or

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

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

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

13 (1) that an enrollee elects to receive in writing in
14 advance of the service with respect to each out-of-network provider
15 providing the service; and

16 (2) for which an out-of-network provider, before
17 providing the service, provides a complete written disclosure to
18 the enrollee that:

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

21 (B) discloses projected amounts for which the
22 enrollee may be responsible; and

23 (C) discloses the circumstances under which the
24 enrollee would be responsible for those amounts.

25 Sec. 1579.111. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER
26 OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section,
27 "diagnostic imaging provider" and "laboratory service provider"
28 have the meanings assigned by Section 1467.001.

29 (b) Except as provided by Subsection (d), the administrator
30 of a managed care plan provided under this chapter shall pay for a
31 covered health care or medical service performed for or a covered

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

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

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

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

22 (1) is based on:

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

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

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

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

31 (1) that an enrollee elects to receive in writing in

1 advance of the service with respect to each out-of-network provider
2 providing the service; and

3 (2) for which an out-of-network provider, before
4 providing the service, provides a complete written disclosure to
5 the enrollee that:

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

8 (B) discloses projected amounts for which the
9 enrollee may be responsible; and

10 (C) discloses the circumstances under which the
11 enrollee would be responsible for those amounts.

12 ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

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

17 (1-a) "Arbitration" means a process in which an
18 impartial arbiter issues a binding determination in a dispute
19 between a health benefit plan issuer or administrator and an
20 out-of-network provider or the provider's representative to settle
21 a health benefit claim.

22 (2-a) "Diagnostic imaging provider" means a health
23 care provider who performs a diagnostic imaging service on a
24 patient for a fee or interprets imaging produced by a diagnostic
25 imaging service.

26 (2-b) "Diagnostic imaging service" means magnetic
27 resonance imaging, computed tomography, positron emission
28 tomography, or any hybrid technology that combines any of those
29 imaging modalities.

30 (2-c) "Emergency care" has the meaning assigned by
31 Section 1301.155.

1 (2-d) [~~2-b~~] "Emergency care provider" means a
2 physician, health care practitioner, facility, or other health care
3 provider who provides and bills an enrollee, administrator, or
4 health benefit plan for emergency care.

5 (3) "Enrollee" means an individual who is eligible to
6 receive benefits through a [~~preferred provider benefit plan or a~~]
7 health benefit plan subject to this chapter [~~under Chapter 1551,~~
8 ~~1575, or 1579~~].

9 (4-b) "Laboratory service provider" means an
10 accredited facility in which a specimen taken from a human body is
11 interpreted and pathological diagnoses are made or a physician who
12 makes an interpretation of or diagnosis based on a specimen or
13 information provided by a laboratory based on a specimen.

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

20 (6-a) "Out-of-network provider" means a diagnostic
21 imaging provider, emergency care provider, facility-based
22 provider, or laboratory service provider that is not a
23 participating provider for a health benefit plan.

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

31 SECTION 2.02. Sections 1467.002, 1467.003, and 1467.005,

1 Insurance Code, are amended to read as follows:

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

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

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

9 (3) [~~2~~] an administrator of a health benefit plan,
10 other than a health maintenance organization plan, under Chapter
11 1551, 1575, or 1579.

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

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

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

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

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

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

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

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

4 (b) The commissioner shall select an organization to
5 maintain a benchmarking database in accordance with this section.

6 The organization may not:

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

10 (2) have any other conflict of interest.

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

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

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

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

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

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

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

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

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

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

6 (b) The commissioner:

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

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

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

16 Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION[+
17 ~~EXCEPTION~~].

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

20 (a) An out-of-network provider or a health benefit plan
21 issuer or administrator [An enrollee] may request mediation of a
22 settlement of an out-of-network health benefit claim through a
23 portal on the department's Internet website if:

24 (1) there is an [the] amount billed by the provider and
25 unpaid by the issuer or administrator [for which the enrollee is
26 ~~responsible to a facility-based provider or emergency care~~
27 ~~provider,] after copayments, deductibles, and coinsurance for
28 which an enrollee may not be billed [including the amount unpaid
29 ~~by the administrator or insurer, is greater than \$500]; and~~~~

30 (2) the health benefit claim is for:

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

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

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

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

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

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

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

1 a mediator.

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

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

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

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

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

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

23 (1) the department; and

24 (2) each other party.

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

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

1 and (i) to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Sec. 1467.0575. RIGHT TO FILE ACTION. Not later than the
19 45th day after the date that the mediator's report is provided to
20 the department under Section 1467.060, either party to a mediation
21 for which there was no agreement may file a civil action to
22 determine the amount due to an out-of-network provider. A party may
23 not bring a civil action before the conclusion of the mediation
24 process under this subchapter.

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

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

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

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

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

5 SUBCHAPTER B-1. MANDATORY BINDING ARBITRATION FOR OTHER PROVIDERS

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

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

14 (b) The commissioner:

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

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

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

27 (b) The determination must take into account:

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

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

1 enrollees for which the provider is an out-of-network provider; and
2 (B) fees paid by the health benefit plan issuer
3 to reimburse similarly qualified out-of-network providers for the
4 same services or supplies in the same region;

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

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

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

13 (5) individual enrollee characteristics;

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

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

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

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

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

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

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

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

7 (2) the health benefit claim is for:

8 (A) emergency care;

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

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

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

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

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

22 (1) the department; and

23 (2) each other party.

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

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

1 proceeding. The rules must provide that:

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

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

6 Sec. 1467.085. EFFECT OF ARBITRATION AND APPLICABILITY OF

7 OTHER LAW. (a) Notwithstanding Section 1467.004, an
8 out-of-network provider or health benefit plan issuer or
9 administrator may not file suit for an out-of-network claim subject
10 to this chapter until the conclusion of the arbitration on the issue
11 of the amount to be paid in the out-of-network claim dispute.

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

14 Sec. 1467.086. SELECTION AND APPROVAL OF ARBITRATOR.

15 (a) If the parties do not select an arbitrator by mutual agreement
16 on or before the 30th day after the date the arbitration is
17 requested, the party requesting the arbitration shall notify the
18 commissioner, and the commissioner shall select an arbitrator from
19 the commissioner's list of approved arbitrators.

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (c) An arbitrator shall provide written notice in the form
6 and manner prescribed by commissioner rule of the reasonable amount
7 for the services or supplies and the binding award amount. If the
8 parties settle before a decision, the parties shall provide written
9 notice in the form and manner prescribed by commissioner rule of the
10 amount of the settlement. The department shall maintain a record of
11 notices provided under this subsection.

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

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

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

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

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

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

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

31 (1) failing to participate in the informal settlement

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

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

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

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

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

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

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

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

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

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

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

4 (3) ensure that a complaint is not dismissed without
5 appropriate consideration[+]

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

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

11 (b) The department and the Texas Medical Board or other
12 appropriate regulatory agency shall maintain information[+]

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

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

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

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

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

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

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

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

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

1 or other appropriate regulatory agency by rule requires.

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

8 ARTICLE 3. CONFORMING AMENDMENTS

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

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

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

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

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

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

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

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

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

- 8 (1) Section 1456.004(c);
- 9 (2) Section 1467.001(2);
- 10 (3) Sections 1467.051(c) and (d);
- 11 (4) Section 1467.0511;
- 12 (5) Sections 1467.053(b) and (c);
- 13 (6) Sections 1467.054(b), (c), (f), and (g);
- 14 (7) Sections 1467.055(d) and (h);
- 15 (8) Section 1467.057;
- 16 (9) Section 1467.058;
- 17 (10) Section 1467.059; and
- 18 (11) Section 1467.151(d).

19 ARTICLE 4. STUDY

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

22 Sec. 38.004. BALANCE BILLING PROHIBITION REPORT. (a) The
23 department shall, each biennium, conduct a study on the impacts of
24 S.B. No. 1264, Acts of the 86th Legislature, Regular Session, 2019,
25 on Texas consumers and health coverage in this state, including:

26 (1) trends in billed amounts for health care or
27 medical services or supplies, especially emergency services,
28 laboratory services, diagnostic imaging services, and
29 facility-based services;

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

1 imaging services, and facility-based services by calendar year and
2 provider type or physician specialty;

3 (3) trends and changes in network participation by
4 providers of emergency services, laboratory services, diagnostic
5 imaging services, and facility-based services by provider type or
6 physician specialty, including whether any terminations were
7 initiated by a health benefit plan issuer, administrator, or
8 provider;

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

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

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

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

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

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

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

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

5 (d) The department:

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

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

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

16 ARTICLE 5. TRANSITION AND EFFECTIVE DATE

17 SECTION 5.01. The changes in law made by this Act apply only
18 to a health care or medical service or supply provided on or after
19 January 1, 2020. A health care or medical service or supply
20 provided before January 1, 2020, is governed by the law in effect
21 immediately before the effective date of this Act, and that law is
22 continued in effect for that purpose.

23 SECTION 5.02. This Act takes effect September 1, 2019.