

## **BILL ANALYSIS**

Senate Research Center  
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C.S.S.B. 1264  
By: Hancock  
Business & Commerce  
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Committee Report (Substituted)

### **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

S.B. 1264 prevents consumers from receiving surprise medical bills so that in situations where the consumer has no choice over who provides their care, they cannot be surprise-billed. The bill prohibits all non-network facility-based providers at network hospitals and all non-network emergency care providers from sending surprise balance bills to consumers. The legislation requires health plans, including preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and health maintenance organizations (HMOs), to pay reasonable or agreed-upon amounts to out-of-network emergency care and facility-based providers. The bill also allows providers to dispute payment amounts through the existing Texas Department of Insurance mediation program. Consumers will still be responsible for their applicable co-pay, coinsurance, and deductible amounts.

S.B. 1264 will apply these surprise billing protections to more than 420,000 Texans enrolled in the Texas Employees Group Benefits plan (ERS), 250,000 Texans enrolled in the Teacher Retirement System (TRS-Care), and 430,000 enrolled in the self-funded TRS-ActiveCare program. Additionally, the legislation allows federally-regulated, self-funded health benefit plans (which make up at least 40 percent of the Texas health insurance market) to opt into the strong state protections afforded under the bill. If a consumer does receive a surprise balance bill, a consumer credit reporting agency is prohibited from reporting information on a medical collection from surprise balance bills. (Original Author's/Sponsor's Statement of Intent)

C.S.S.B. 1264 amends current law relating to consumer protections against certain medical and health care billing by certain out-of-network providers; and authorizes a fee.

### **RULEMAKING AUTHORITY**

Rulemaking authority is expressly granted to a certain regulatory agency in SECTION 1.01 (Code Section 752.0002, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 2.05 (Section 1467.050, Insurance Code) of this bill.

Rulemaking authority previously granted to the chief administrative law judge is rescinded in SECTION 2.02 (Section 1467.003, Insurance Code) of this bill.

Rulemaking authority previously granted to the commissioner of insurance and the Texas Medical Board is modified in SECTION 2.11 (Section 1467.151, Insurance Code) of this bill.

### **SECTION BY SECTION ANALYSIS**

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

SECTION 1.01. Amends Subtitle G, Title 5, Insurance Code, by adding Chapter 752, as follows:

#### CHAPTER 752. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS

Sec. 752.0001. INJUNCTION FOR BALANCE BILLING. (a) Authorizes the Texas attorney general (attorney general), if the attorney general believes that an individual or entity is violating a law prohibiting the individual or entity from billing an insured, participant, or enrollee in an amount greater than the insured's, participant's, or enrollee's responsibility under the insured's, participant's, or enrollee's managed care plan, to bring a civil action in the name of the state to enjoin the individual or entity from the violation.

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

Sec. 752.0002. ENFORCEMENT BY REGULATORY AGENCY. (a) Authorizes 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 to take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law prohibiting the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than the insured's, participant's, or enrollee's responsibility under the insured's, participant's, or enrollee's managed care plan.

(b) Authorizes a regulatory agency described by Subsection (a) to adopt rules necessary to implement this section.

SECTION 1.02. Amends Subchapter A, Chapter 1271, Insurance Code, by adding Section 1271.008, as follows:

Sec. 1271.008. BALANCE BILLING PROHIBITION NOTICE. Requires a health maintenance organization to provide written notice of the billing prohibitions provided by Sections 1271.155 (Emergency Care), 1271.157, and 1271.158 in each explanation of benefits provided to an enrollee or a physician or provider in connection with a health care service that is subject to one of these sections.

SECTION 1.03. Amends Section 1271.155, Insurance Code, by adding Subsection (f), as follows:

(f) Prohibits a non-network physician or provider, for emergency care subject to this section, from billing an enrollee in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 1.04. Amends Subchapter D, Chapter 1271, Insurance Code, by adding Sections 1271.157 and 1271.158, as follows:

Sec. 1271.157. NON-NETWORK FACILITY-BASED PROVIDERS. (a) Defines "facility-based provider" for purposes of this section.

(b) Requires a health maintenance organization to pay for a health care service performed by for 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.

(c) Prohibits a non-network facility-based provider from billing an enrollee receiving a health care service described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's health care plan, including an applicable copayment, coinsurance, or deductible.

Sec. 1271.158. NON-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY. (a) Defines "diagnostic imaging provider" and "laboratory" for purposes of this section.

(b) Requires a health maintenance organization to pay for a health care service performed by a non-network diagnostic imaging provider or laboratory at the usual and customary rate or at an agreed rate if the provider or laboratory performed the service in connection with a health care service performed by a network physician or provider.

(c) Prohibits a non-network diagnostic imaging provider or laboratory from billing an enrollee receiving a health care service described by Subsection (b) in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 1.05. Amends Section 1301.0053, Insurance Code, as follows:

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE.

(a) Creates this subsection from existing text and requires the issuer of the plan, if an out-of-network provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, to reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services, rather than requiring the issuer of the plan, if a nonpreferred provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, to reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider for the provision of the services.

(b) Prohibits an out-of-network provider, for emergency care subject to this section, from billing an insured in, and provides that the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's exclusive provider benefit plan, including an applicable copayment, coinsurance, or deductible.

SECTION 1.06. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Section 1301.010, as follows:

Sec. 1301.010. BALANCE BILLING PROHIBITION NOTICE. Requires an insurer to provide written notice of the billing prohibitions provided by Sections 1301.0053, 1301.155, 1301.164, and 1301.165 in each explanation of benefits provided to an insured or physician or health care provider in connection with a medical care or health care service that is subject to one of these sections.

SECTION 1.07. Amends Section 1301.155, Insurance Code, by amending Subsection (b) and adding Subsection (c), as follows:

(b) Requires an insurer, if an insured cannot reasonably reach a preferred provider, to provide reimbursement for certain specified 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.

(c) Prohibits an out-of-network provider, for emergency care subject to this section, from billing an insured in, and provides that the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's preferred provider benefit plan, including an applicable copayment, coinsurance, or deductible.

SECTION 1.08. Amends Subchapter D, Chapter 1301, Insurance Code, by adding Section 1301.164 and 1301.165, as follows:

Sec. 1301.164. OUT-OF-NETWORK FACILITY-BASED PROVIDER. (a) Defines "facility-based provider" for purposes of this section.

(b) Requires an insurer to pay for a health care service performed for 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.

(c) Prohibits an out-of-network provider who is a facility-based provider from billing an insured receiving a health care service described by Subsection (b) in, and provides that the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's preferred provider benefit plan, including an applicable copayment, coinsurance, or deductible.

Sec. 1301.165. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY. (a) Defines "diagnostic imaging provider" and "laboratory" for purposes of this section.

(b) Requires an insurer to pay for a medical care or health care service performed by an out-of-network provider who is a diagnostic imaging provider or laboratory at the usual and customary rate or at an agreed rate if the provider or laboratory performed the service in connection with a medical care or health care service performed by a preferred provider.

(c) Prohibits an out-of-network provider who is a diagnostic imaging provider or laboratory from billing an insured receiving medical care or health care service described by Subsection (b) in, provides that and the insured does not have financial responsibility for, an amount greater than the insured's responsibility under the insured's preferred provider benefit plan, including an applicable copayment, coinsurance, or deductible.

SECTION 1.09. Amends Section 1551.003, Insurance Code, by adding Subdivision (15), to define "usual and customary rate" for purposes of this chapter (Texas Employees Group Benefits Act).

SECTION 1.10. Amends Subchapter A, Chapter 1551, Insurance Code, by adding Section 1551.015, as follows:

Sec. 1551.015. BALANCE BILLING PROHIBITION NOTICE. Requires the administrator of a managed care plan provided under the group benefits program to provide written notice of the billing prohibitions provided by Sections 1551.228, 1551.229, and 1551.230 in each explanation of benefits provided to a participant or a physician or health care provider in connection with a health care service that is subject to one of these sections.

SECTION 1.11. Amends Subchapter E, Chapter 1551, Insurance Code, by adding Sections 1551.228, 1551.229, and 1551.230, as follows:

Sec. 1551.228. EMERGENCY CARE COVERAGE. (a) Defines "emergency care" for purposes of this section.

(b) Requires a managed care plan provided under the group benefits program to provide out-of-network emergency care coverage for participants in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for emergency care performed by an out-of-network provider at the usual and customary rate or at an agreed rate.

(d) Prohibits an out-of-network provider, for emergency care subject to this section, from billing a participant in, and provides that the participant does not have financial responsibility for, an amount greater than the participant's

responsibility under the participant's managed care plan, including an applicable copayment, coinsurance, or deductible

**Sec. 1551.229. OUT-OF-NETWORK FACILITY-BASED PROVIDER COVERAGE.**

(a) Defines "facility-based provider" for purposes of this section.

(b) Requires a managed care plan provided under the group benefits program to provide out-of-network facility-based provider to provide coverage for participants in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for a health care service performed for 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.

(d) Prohibits an out-of-network provider who is a facility-based provider from billing a participant receiving a health care service described by Subsection (c) in, and provides that the participant does not have financial responsibility for, an amount greater than the participant's responsibility under the participant's managed care plan, including an applicable copayment, coinsurance or deductible.

**Sec. 1551.230. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY.** (a) Defines "diagnostic imaging provider" and "laboratory" for purposes of this section.

(b) Requires a managed care plan provided under the group benefits program to provide out-of-network diagnostic imaging provider and laboratory coverage for participants in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for a health care service performed for a participant by an out-of-network provider who is a diagnostic imaging provider or laboratory 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 participating provider.

(d) Prohibits an out-of-network provider who is a diagnostic imaging provider or laboratory from billing a participant receiving a health care service described by Subsection (c) in, and provides that the participant does not have financial responsibility for, an amount greater than the participant's responsibility under the participant's managed care plan, including an applicable copayment, coinsurance or deductible .

**SECTION 1.12.** Amends Section 1575.002, Insurance Code, by adding Subdivision (8), to define "usual and customary rate" for purposes of this chapter (Texas Public School Employees Group Benefits Program).

**SECTION 1.13.** Amend Subchapter A, Chapter 1575, Insurance Code, by adding Section 1575.009, as follows:

**Sec. 1575.009. BALANCE BILLING PROHIBITION NOTICE.** Requires the administrator of a managed care plan provided under the group program to provide written notice of the billing prohibitions provided by Sections 1575.171, 1575.172, and 1575.173 in each explanation of benefits provided to an enrollee or a physician or health care provider in connection with a health care service that is subject to one of these sections.

**SECTION 1.14.** Amends Subchapter D, Chapter 1575, Insurance Code, by adding Sections 1575.171, 1575.172, and 1575.173, as follows:

Sec. 1575.171. EMERGENCY CARE COVERAGE. (a) Defines "emergency care" for purposes of this section.

(b) Requires a managed care plan provided under the group program to provide out-of-network emergency care coverage in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for emergency care performed by an out-of-network provider at the usual and customary rate or at an agreed rate.

(d) Prohibits an out-of-network provider, for emergency care subject to this section, from billing an enrollee in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

Sec. 1575.172. OUT-OF-NETWORK FACILITY-BASED PROVIDER COVERAGE.

(a) Defines "facility-based provider" for purposes of this section.

(b) Requires a managed care plan provided under the group program to provide out-of-network facility-based provider coverage for enrollees in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for health care service performed for an enrollee by an out-of-network 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.

(d) Prohibits an out-of-network provider who is a facility-based provider from billing an enrollee receiving a health care service described by Subsection (c) in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

Sec. 1575.173. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY. (a) Defines "diagnostic imaging provider" and "laboratory" for purposes of this section.

(b) Requires a managed care plan provided under the group benefits program to provide out-of-network diagnostic imaging provider and laboratory coverage for enrollees in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for a health care service performed for an enrollee by an out-of-network provider who is a diagnostic imaging provider at the usual and customary rate or at an agreed rate if the provider or laboratory performed the service in connection with a health care service performed by a participating provider.

(d) Prohibits an out-of-network provider who is diagnostic imaging provider or laboratory from billing an enrollee receiving a health care service described by Subsection (c) in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 1.15. Amends Section 1579.002, Insurance Code, by adding Subdivision (8), to define "usual and customary rate" for purposes of this chapter (Texas School Employees Uniform Group Health Coverage).

SECTION 1.16. Amends Subchapter A, Chapter 1579, Insurance Code, by adding Section 1579.009, as follows:

Sec. 1579.009. **BALANCE BILLING PROHIBITION NOTICE.** Requires the administrator of a managed care plan provided under this chapter to provide written notice of the billing prohibitions provided by Sections 1579.109, 1579.110, and 1579.111 in each explanation of benefits provided to an enrollee or a physician or health care provider in connection with a health care service that is subject to one of these sections.

SECTION 1.17. Amends Subchapter C, Chapter 1579, Insurance Code, by adding Sections 1579.109, 1579.110, and 1579.111, as follows:

Sec. 1579.109. **EMERGENCY CARE COVERAGE.** (a) Defines "emergency care" for purposes of this section.

(b) Requires a managed care plan provided under this chapter to provide out-of-network emergency care coverage in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for emergency care performed for an enrollee by an out-of-network provider at the usual and customary rate or at an agreed rate.

(d) Prohibits an out-of-network provider, for emergency care subject to this section, from billing an enrollee in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

Sec. 1579.110. **OUT-OF-NETWORK FACILITY-BASED PROVIDER COVERAGE.** (a) Defines "facility-based provider" for purposes of this section.

(b) Requires a managed care plan provided under this chapter to provide out-of-network facility-based provider coverage to enrollees in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for a health care service performed for an enrollee by an out-of-network provider who is a facility-based provider in 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.

(d) Prohibits an out-of-network provider who is a facility-based provider, from billing an enrollee in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

Sec. 1579.111. **OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY.** (a) Defines "diagnostic imaging provider" and "laboratory" for purposes of this section.

(b) Requires a managed care plan provided under this chapter to provide out-of-network diagnostic imaging provider and laboratory coverage for enrollees in accordance with this section.

(c) Requires the coverage to require the administrator of the plan to pay for health care service performed for an enrollee by an out-of-network who is a diagnostic imaging provider or laboratory at the usual and customary rate or at an agreed rate if the provider or laboratory performed the service in connection with a health care service performed by a participating provider.

(d) Prohibits an out-of-network provider who is a diagnostic imaging provider or laboratory from billing an enrollee receiving a health care service described by Subsection (c) in, and provides that the enrollee does not have financial responsibility for, an amount greater than the enrollee's responsibility under the enrollee's managed care plan, including an applicable copayment, coinsurance, or deductible.

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

SECTION 2.01. Amends Section 1467.001, Insurance Code, by adding Subdivisions (1-a), (2-c), (2-d), (4-b), and (6-a) and amending Subdivisions (2-a), (2-b), (3), and (7), to define "arbitration," "diagnostic imaging provider," "diagnostic imaging service," "emergency care," "emergency care provider," "laboratory," and "out-of-network provider" and to redefine "enrollee" and "party" for purposes of this chapter (Out-of-Network Claim Dispute Resolution).

SECTION 2.02. Amends Sections 1467.002, 1467.003, and 1467.005, Insurance Code, as follows:

Sec. 1467.002. APPLICABILITY OF CHAPTER. Redesignates existing Subdivision (2) as Subdivision (3). Provides that this chapter applies to a health benefit plan offered by a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations), a preferred provider benefit plan, including an exclusive provided benefit plan, offered by an insurer under Chapter 1301 (Preferred Provider Benefit Plans), and an administrator of a managed care plan, rather than health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.

Sec. 1467.003. RULES. Removes the chief administrative law judge from a list of officials required to adopt rules as necessary to implement their respective powers and duties under this chapter.

Sec. 1467.005. REFORM. Prohibits this chapter from being construed to prohibit:

- (1) a health benefit plan issuer, rather than an insurer offering a preferred provider benefit plan, or administrator from, at any time, offering a reformed claim settlement; or
- (2) an out-of-network provider, rather than 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. Amends Subchapter A, Chapter 1467, Insurance Code, by adding Section 1467.006, as follows:

Sec. 1467.006. BENCHMARKING DATABASE. (a) Requires the commissioner of insurance (commissioner) to select an organization to maintain a benchmarking database that contains information necessary to calculate, with respect to a health care or medical service or supply, for each geographical area in this state:

- (1) the 80th percentile of billed amounts of all physicians or health care providers; and
- (2) the 50th percentile of rates paid to participating providers.

(b) Prohibits the commissioner from selecting under Subsection (a) and organization that is financially affiliated with a health benefit plan issuer.

SECTION 2.04. Amends the heading to Subchapter B, Chapter 1467, to read as follows:

### SUBCHAPTER B. MANDATORY BINDING ARBITRATION



SECTION 2.05. Amends Subchapter B, Chapter 1467, Insurance Code, by adding Sections 1467.050 and 1467.0505, as follows:

Sec. 1467.050. ESTABLISHMENT AND ADMINISTRATION OF ARBITRATION PROGRAM. (a) Requires the commissioner to establish and administer an arbitration program to resolve disputes over out-of-network provider amounts in accordance with this subchapter (Mandatory Mediation).

(b) Provides that the commissioner:

(1) is required to adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program;

(2) is authorized to impose a fee on the parties participating in the program as necessary to cover the cost of implementation and administration of the arbitration program and to evenly split the costs of the arbitrator between the parties; and

(3) is required to maintain a list of qualified arbitrators for the program.

Sec. 1467.0505. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) Provides that the only issue that an arbitrator is authorized to 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) Requires the determination to 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 amount 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 amounts for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database described by Section 1467.006; and

(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 geographical area as reported in a benchmarking database described by Section 1467.006.

SECTION 2.06. Amends the heading to Section 1467.051, Insurance Code, to read as follows:

Sec. 1467.051. AVAILABILITY OF MANDATORY ARBITRATION.

SECTION 2.07. Amends Section 1467.051, Insurance Code, by amending Subsections (a) and (b) and adding Subsections (e), (f), (g), and (h), as follows:

(a) Authorizes an out-of-network provider, health benefit plan issuer, or administrator, rather than an enrollee, to request arbitration, rather than mediation, of a settlement of an out-of-network health benefit claim if:

(1) there is an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance, rather than the amount for which the enrollee is responsible to a facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than \$500;

(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, rather than preferred, provider or that has a contract with the administrator;

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

(D) an out-of-network diagnostic imaging service; and

(3) the provider and the issuer or administrator have exhausted the issuer's or administrator's internal dispute resolution process.

(b) Requires the out-of-network provider or the provider's representative, and the health benefit plan issuer, or the administrator, as appropriate, if a person requests arbitration under this subchapter, to participate in the arbitration, rather than requiring the facility-based provider or emergency care provider, or the provider's representative, and the insurer or the administrator, as appropriate, except as provided by Subsections (c) and (d), if an enrollee requests mediation under this subchapter, to participate in the mediation.

(e) Requires the person who request the arbitration to provide written notice on the date the arbitration is requested to:

(1) the Texas Department of Insurance (TDI) in the form and manner prescribed by commissioner rule; and

(2) each other party.

(f) Requires the party, not later than the 15th day after the date a party receives notice of a request under Subsection (e), to provide written notice to the person requesting the arbitration that the party received notice of the arbitration request.

(g) Requires TDI to post on TDI's Internet website a mailing address and e-mail address to receive notice under this section. Requires a party, if the party has not previously participated in an arbitration under this subchapter, to provide TDI with a mailing address and e-mail address to receive notice under this section.

(h) Requires all parties, in an effort to settle the claim before arbitration, to participate in an informal settlement teleconference not later than the 30th day after the date on which the person requesting the arbitration receives notice under Subsection (f) from all other parties.

SECTION 2.08. Amends Subchapter B, Chapter 1467, Insurance Code, by adding Section 1467.0515, as follows:

Sec. 1467.0515. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Provides that each party to an arbitration under this subchapter waives a right to pursue any other legal action until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

(b) Provides that an arbitration conducted under this subchapter is not subject to Title 7 (Alternate Methods of Dispute Resolution), Civil Practices and Remedies Code.

SECTION 2.09. Amends Subchapter B, Chapter 1467, Insurance Code, by adding Sections 1467.0535, 1467.0545, 1467.0555, and 1467.0565, as follows:

Sec. 1467.0535. SELECTION AND APPROVAL OF ARBITRATOR. (a) Requires the commissioner, if the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is initiated, to select an arbitrator from the commissioner's list of qualified arbitrators.

(b) Requires an individual, to be eligible to serve as an arbitrator, to be knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally and be approved by the commissioner.

(c) Requires the commissioner, in approving an individual as an arbitrator, to 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. Provides that a conflict of interest includes current or recent ownership or employment of the individual or a close family member in a health benefit plan issuer or out-of-network provider that may be involved in the arbitration.

(d) Requires the commissioner to 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. 1467.0545. PROCEDURES. (a) Requires the arbitrator to set a date for submission of all information to be considered by the arbitrator.

(b) Prohibits a party from engaging in discovery in connection with the arbitration.

(c) Authorizes a deadline under this subchapter, on agreement of all parties, to be extended.

Sec. 1467.0555. DECISION. (a) Requires an arbitrator, not later than the 10th day after the deadline for submission of information, to provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed amount of the initial payment made by the health benefit plan issuer or administrator is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.0505(b); and

(2) selects the amount described by Subdivision (1) as the binding award amount.

(b) Prohibits an arbitrator from modifying the binding award amount selected under Subsection (a).

Sec. 1467.0565. EFFECT OF DECISION. (a) Provides that an arbitrator's decision under Section 1467.0555 is binding.

(b) Authorizes a party not satisfied with the decision, not later than the 90th day after the date of an arbitrator's decision under Section 1467.0555, to file an action to determine the payment due to an out-of-network provider.

(c) Provides that an action filed under Subsection (b) is by trial de novo. Provides that the arbitrator's decision under Section 1467.0555 is admissible to demonstrate the arbitrator's determination of the reasonable amount for the services or supplies provided by the out-of-network provider.

SECTION 2.10. Amends Subchapter C, Chapter 1467, Insurance Code, as follows:

New heading: SUBCHAPTER C. BAD FAITH PARTICIPATION

Sec. 1467.101. BAD FAITH. Deletes existing Subsections (a)-(b). Provides that the following conduct constitutes bad faith participation, rather than bad faith mediation, for purposes of this chapter:

(1) failing to participate in the informal settlement teleconference under Section 1467.051(h) or arbitration under Subchapter B, rather than mediation;

(2) failing to provide information the arbitrator believes is necessary to facilitate a decision, rather than failing to provide information the mediator believes is necessary to facilitate an agreement;

(3) failing to designate a representative participating in the arbitration with full authority to enter into any agreement, rather than failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement; or

(4) failing to appear for the arbitration.

Sec. 1467.102. PENALTIES. Deletes existing Subsections (a)-(b). Provides that bad faith participation or otherwise failing to comply with this chapter, rather than bad faith mediation, 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.

SECTION 2.11. Amends Sections 1467.151(a), (b), and (c), Insurance Code, as follows:

(a) Deletes existing Subdivisions (4)–(5). Requires the rules adopted by the commissioner and the Texas Medical Board (TMB) or other regulatory agency, as appropriate, to regulate complaints under this section to:

(1) makes no changes to this subdivision;

(2) develop a form for filing a complaint, rather than 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.

(b) Deletes existing Subdivisions (1)–(2) and redesignates existing Paragraphs (A)–(E) as Subdivisions (1)–(5) and makes nonsubstantive changes throughout. Requires TDI and TMB or the other appropriate regulatory agency to maintain information on each complain filed that concerns a claim or arbitration, rather than mediation, subject to this chapter, including:

(1) the type of services or supplies that gave rise to the dispute;

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

(3)–(4) makes no further changes to these subdivisions; and

(5) any other information about:

(A) the health benefit plan issuer, rather than insurer, or administrator that the commissioner by rule requires; or

(B) the out-of-network provider that TMB or the other appropriate regulatory agency by rule requires, rather than the facility-based provider or emergency care provider that TMB or the other appropriate regulatory agency by rule requires.

(c) Provides that the information collected and maintained under Subsection (b) is public information as defined by Section 552.002 (Definition of Public Information, Media Containing Public Information), Government Code, and is prohibited from including personally identifiable information or health care or medical information, rather than providing that the information collected and maintained by TDI and TMB and other appropriate regulatory agencies under Subsection (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. Amends Section 1456.001(6), Insurance Code, to redefine "provider network."

SECTION 3.02. Amends Sections 1456.002(a) and (c), Insurance Code, as follows:

(a) Deletes existing text providing that this chapter (Physicians and Health Care Providers) applies to any health benefit plan that provides certain benefits, including a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations), and makes nonsubstantive changes to this subsection.

(c) Provides that this chapter does not apply to a health benefit plan subject to Section 1251.157, 1301.164, 1551.229, 1575.172, or 1579.110.

SECTION. 3.03. Repealer: Section 1456.004(c) (relating to requiring certain facility-based physicians to send a billing statement to the patient that contains a conspicuous, plain-language explanation of the mandatory mediation process available), Insurance Code

Repealer Section 1467.001(2) (relating to the definition of "chief administrative law judge"), Insurance Code.

Repealer Section 1467.001(5) (relating to the definition of "mediation"), Insurance Code.

Repealer Section 1467.001(6) (relating to the definition of "mediator"), Insurance Code.

Repealer: Section 1467.051(c) (relating to a requirement that a facility-based provider provide a complete disclosure to an enrollee), Insurance Code.

Repealer: Section 1467.051(d) (relating to providing that a facility-based provider who makes a certain disclosure may not be required to mediate a billed charge), Insurance Code.

Repealer Section 1467.052 (Mediator Qualifications), Insurance Code.

Repealer Section 1467.053 (Appointment of Mediator; Fees), Insurance Code.

Repealer Section 1467.054 (Request and Preliminary Procedures For Mandatory Mediation), Insurance Code.

Repealer Section 1467.055 (Conduct of Mediation; Confidentiality), Insurance Code.

Repealer Section 1467.056 (Matters Considered in Mediation; Agreed Resolution), Insurance Code.

Repealer Section 1467.057 (No Agreed Resolution), Insurance Code.

Repealer Section 1467.058 (Continuation of Mediation), Insurance Code.

Repealer Section 1467.060 (Report of Mediator), Insurance Code.

Repealer: Section 1467.151(d) (relating to a provision that a facility-based provider or emergency care provider who fails to provide a certain disclosure is not subject to discipline), Insurance Code.

#### ARTICLE 4. STUDY

SECTION 4.01. Amends Subchapter A, Chapter 38, Insurance Code, by adding Section 38.004, as follows:

Sec. 38.004. **BALANCE BILLING PROHIBITION REPORT.** (a) Requires TDI to, 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 charges for health care services, 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 of 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) the number of complaints, completed investigations, and disciplinary sanctions for billing by providers of emergency services, laboratory services, diagnostic imaging services, and facility-based services of

insureds, enrollees, or plan participants for amounts greater than the insured's enrollee's or participant's responsibility under an applicable managed care plan, including an applicable copayment, coinsurance, or deductible; and

(5) trends in amounts paid to out-of-network providers.

(b) Requires TDI, in conducting the study described by Subsection (a), to collect settlement data and verdicts or arbitration awards from parties to arbitration under Chapter 1467.

(c) Authorizes TDI to:

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

(2) utilize any reliable external resources or entity to acquire information reasonably necessary to proper the report require by Subsection (d).

(d) Requires TDI, not later December 1 of each even-numbered year, to prepare and submit a written report on the results of the study under this section, including TDI's findings, to the legislature.

## ARTICLE 5. TRANSITION AND EFFECTIVE DATE

SECTION 5.01. Makes application of this Act prospective.

SECTION 5.02. Provides that TDI, the Employees Retirement System of Texas, the Teacher Retirement System of Texas, and any other state agency subject to this Act are required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. Authorizes, but does not require, those agencies, if the legislature does not appropriate money specifically for that purpose, to implement a provision of this Act using other appropriations available for that purpose.

SECTION 5.03. Effective date: September 1, 2019.