By: Oliverson H.B. No. 2967

A BILL TO BE ENTITLED

AN ACT

relating to prohibited balance billing and an independent dispute resolution program for out-of-network coverage under certain managed care plans; authorizing a fee.

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

SECTION 1. Subtitle C, Title 8, Insurance Code, is amended by adding Chapter 1275 to read as follows:

CHAPTER 1275. ENROLLEE RESPONSIBILITY FOR COVERED OUT-OF-NETWORK SERVICES

Sec. 1275.0001. DEFINITIONS. In this chapter:

(1) "Enrollee" means an individual who is eligible for coverage under a health benefit plan.

(2) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that provides benefits for health care services. The term does not include:

(A) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(B) the child health plan program operated under Chapter 62, Health and Safety Code;

(C) Medicare benefits; or

(D) benefits designated as excepted benefits

under 42 U.S.C. Section 300gg-91(c).

(3) "Health benefit plan issuer" means an entity authorized to engage in business under this code or another insurance law of this state that issues or offers to issue a health benefit plan in this state, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(4) "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility licensed to provide health care services.

(5) "Health care practitioner" means an individual who is licensed to provide and provides health care services.

(6) "Health care provider" means a health care practitioner or health care facility.

(7) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) any other health benefit plan issuer.

(8) "Out-of-network provider" means a health care provider who is not a participating provider.

(9) "Participating provider" means a health care provider, including a preferred provider, who has contracted with a health benefit plan issuer to provide services to enrollees.

(10) "Usual, customary, and reasonable rate" has the meaning assigned by Section 1467.201.

Sec. 1275.0002. APPLICABILITY OF CHAPTER. This chapter applies only with respect to a managed care plan.

Sec. 1275.0003. CERTAIN PLANS EXCLUDED. This chapter does not apply to a service covered by a health benefit plan subject to Subchapter B, Chapter 1467.

Sec. 1275.0004. BALANCE BILLING PROHIBITED. (a) A health benefit plan issuer shall pay for a covered service performed for an enrollee under the health benefit plan by an out-of-network provider at the usual, customary, and reasonable rate or at an agreed rate.

(b) An out-of-network provider may not bill an enrollee in, and the enrollee has no 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 2. Chapter 1467, Insurance Code, is amended by adding Subchapter E to read as follows:

SUBCHAPTER E. INDEPENDENT DISPUTE RESOLUTION PROGRAM

Sec. 1467.201. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" means an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that provides benefits for health care services. The term does not include:

(A) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(B) the child health plan program operated under Chapter 62, Health and Safety Code;

(C) Medicare benefits; or

(D) benefits designated as excepted benefits under 42 U.S.C. Section 300gg-91(c).

(2) "Health benefit plan issuer" means an entity authorized to engage in business under this code or another insurance law of this state that issues or offers to issue a health benefit plan in this state, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(3) "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility licensed to provide health care services.

(4) "Health care provider" means a health care practitioner or health care facility.

(5) "Managed care plan" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer; or

(C) any other health benefit plan issuer.

(6) "Out-of-network provider" means a health care provider who is not a participating provider.

(7) "Participating provider" means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

(8) "Usual, customary, and reasonable rate" means the 80th percentile of all charges for a particular health care service 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 1467.203.

Sec. 1467.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only with respect to a managed care plan.

Sec. 1467.203. BENCHMARKING DATABASE. (a) The commissioner shall select a nonprofit organization to maintain a benchmarking database that contains information necessary to calculate the usual, customary, and reasonable rate for each

geographical area in this state.

(b) The commissioner may not select under Subsection (a) a nonprofit organization that is financially affiliated with a health benefit plan issuer.

Sec. 1467.204. ESTABLISHMENT AND ADMINISTRATION OF PROGRAM. (a) The commissioner shall establish and administer an independent dispute resolution program to resolve disputes over out-of-network provider charges, including balance billing, in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the independent dispute resolution program;

(2) may impose a fee on the parties participating in the program as necessary to cover the cost of implementation and administration of the program; and

(3) shall maintain a list of qualified reviewers for the program.

Sec. 1467.205. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) The only issue that an independent reviewer may determine in a hearing under the independent dispute resolution program is the reasonable charge for the health care services provided to the enrollee by an out-of-network provider.

(b) The determination must take into account:

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

(A) fees paid to the out-of-network provider for

the same services 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 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 charge for comparable services 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 service;

(5) individual enrollee characteristics; and

(6) the usual, customary, and reasonable rate for the health care service.

Sec. 1467.206. INITIATION OF PROCESS. (a) A health benefit plan issuer or out-of-network provider may initiate an independent dispute resolution process in the form and manner provided by commissioner rule to determine the amount of reimbursement for a health care service provided by the provider.

(b) A party may respond to the claims made by the party initiating the independent dispute resolution process under Subsection (a) not later than the 15th day after the date the process is initiated. If the responding party fails to respond, that party accepts the claims made by the initiating party.

Sec. 1467.207. SELECTION AND APPROVAL OF INDEPENDENT REVIEWERS. (a) If the parties do not select an independent

reviewer by mutual agreement on or before the 30th day after the date the independent dispute resolution process is initiated, the commissioner shall select a reviewer from the commissioner's list of qualified reviewers.

(b) To be eligible to serve as an independent reviewer, an individual must be knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

(c) In approving an individual as an independent reviewer, the commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an independent dispute resolution process. 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 process.

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

Sec. 1467.208. PROCEDURES. (a) A party to an independent dispute resolution process may request an oral hearing.

(b) If an oral hearing is not requested, the independent reviewer shall set a date for submission of all information to be considered by the reviewer.

(c) A party to an independent dispute resolution process shall submit a binding award amount to the independent reviewer.

(d) An independent reviewer may make procedural rulings during an oral hearing.

(e) A party may not engage in discovery in connection with an independent dispute resolution process.

Sec. 1467.209. DECISION. (a) Not later than the 10th day after the date of an oral hearing or the deadline for submission of information, as applicable, an independent reviewer shall provide the parties with a written decision in which the reviewer determines which binding award amount submitted under Section 1467.208 is the closest to the reasonable charge for the services provided in accordance with Section 1467.205(b).

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

(c) The decision described by Subsection (a) is binding and final. The prevailing party may seek enforcement of the decision in any court of competent jurisdiction.

Sec. 1467.210. ATTORNEY'S FEES AND COSTS. Unless otherwise agreed by the parties to an independent dispute resolution process, each party shall:

(1) bear the party's own attorney's fees and costs; and

(2) equally split the fees and costs of the independent reviewer.

SECTION 3. Sections 1467.001(3), (5), and (7), Insurance Code, are amended to read as follows:

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

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

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

SECTION 4. Section 1467.002, Insurance Code, is amended to read as follows:

Sec. 1467.002. APPLICABILITY OF CHAPTER. Except as provided by Subchapter E, this [~~This~~] chapter applies only to[~~:~~

[~~(1) a preferred provider benefit plan offered by an insurer under Chapter 1301; and~~

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

SECTION 5. Section 1467.005, Insurance Code, is amended to read as follows:

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

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

settlement; or

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

(a) An enrollee may request mediation of a settlement of an out-of-network health benefit claim if:

(1) 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; and

(2) the health benefit claim is for:

(A) emergency care; or

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator.

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

SECTION 7. Section 1467.0511, Insurance Code, is amended to read as follows:

Sec. 1467.0511. NOTICE AND INFORMATION PROVIDED TO ENROLLEE. (a) A bill sent to an enrollee by a facility-based

provider or emergency care provider or an explanation of benefits sent to an enrollee by an [~~insurer or~~] administrator for an out-of-network health benefit claim eligible for mediation under this chapter must contain, in not less than 10-point boldface type, a conspicuous, plain-language explanation of the mediation process available under this chapter, including information on how to request mediation and a statement that is substantially similar to the following:

"You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at (website) and (phone number)."

(b) If an enrollee contacts an [~~insurer,~~] administrator, facility-based provider, or emergency care provider about a bill that may be eligible for mediation under this chapter, the [~~insurer,~~] administrator, facility-based provider, or emergency care provider is encouraged to:

(1) inform the enrollee about mediation under this chapter; and

(2) provide the enrollee with the department's toll-free telephone number and Internet website address.

SECTION 8. Section 1467.052(c), Insurance Code, is amended to read as follows:

(c) A person may not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with [~~an insurer offering the preferred provider benefit plan or~~] a physician, health care

practitioner, or other health care provider during the three years immediately preceding the request for mediation.

SECTION 9. Section 1467.053(d), Insurance Code, is amended to read as follows:

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

SECTION 10. Sections 1467.054(b) and (c), Insurance Code, are amended to read as follows:

(b) A request for mandatory mediation must be provided to the department on a form prescribed by the commissioner and must include:

(1) the name of the enrollee requesting mediation;

(2) a brief description of the claim to be mediated;

(3) contact information, including a telephone number, for the requesting enrollee and the enrollee's counsel, if the enrollee retains counsel;

(4) the name of the facility-based provider or emergency care provider and name of the [~~insurer or~~] administrator; and

(5) any other information the commissioner may require by rule.

(c) On receipt of a request for mediation, the department shall notify the facility-based provider or emergency care provider and [~~insurer or~~] administrator of the request.

SECTION 11. Section 1467.055(i), Insurance Code, is amended to read as follows:

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

SECTION 12. Sections 1467.056(a), (b), and (d), Insurance Code, are amended to read as follows:

(a) In a mediation under this chapter, the parties shall:

(1) evaluate whether:

(A) the amount charged by the facility-based provider or emergency care provider for the health care or medical service or supply is excessive; and

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

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

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

(d) The goal of the mediation is to reach an agreement among the enrollee, the facility-based provider or emergency care provider, and the [~~insurer or~~] administrator[~~, as applicable,~~] as

to the amount paid by the [~~insurer or~~] administrator to the facility-based provider or emergency care provider, the amount charged by the facility-based provider or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee.

SECTION 13. Section 1467.058, Insurance Code, is amended to read as follows:

Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral is made under Section 1467.057, the facility-based provider or emergency care provider and the [~~insurer or~~] administrator may elect to continue the mediation to further determine their responsibilities. Continuation of mediation under this section does not affect the amount of the billed charge to the enrollee.

SECTION 14. Section 1467.151(b), Insurance Code, is amended to read as follows:

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

(1) on each complaint filed that concerns a claim or mediation subject to this chapter; and

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

(A) the type of services that gave rise to the dispute;

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

(C) the county and metropolitan area in which the

health care or medical service or supply was provided;

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

(E) any other information about:

(i) the [~~insurer or~~] administrator that the commissioner by rule requires; or

(ii) the facility-based provider or emergency care provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.

SECTION 15. The changes in law made by this Act apply only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2020. A health benefit plan delivered, issued for delivery, or renewed before January 1, 2020, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 16. This Act takes effect September 1, 2019.