BILL ANALYSIS

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S.B. 1264
By: Hancock
Business & Commerce
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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.

As proposed, S.B. 1264 amends current law relating to consumer protections against billing and limitations on information reported by consumer reporting agencies.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

ARTICLE 1. LIMITATIONS ON SURPRISE BILLING INFORMATION REPORTED BY CONSUMER REPORTING AGENCIES

SECTION 1.01. Amends Section 20.05, Business and Commerce Code, by amending Subsection (a) and adding Subsection (d), as follows:

> (a) Prohibits a consumer reporting agency, except as provided by subsection (b), from furnishing a consumer report containing information related to:
>
> > (1)–(3) makes no changes to these subdivisions;
> >
> > (4) makes a nonsubstantive change to this subdivision;
> >
> > (5) a collection account with a medical industry code, if the consumer was covered by a health benefit plan at the time of the event giving rise to the collection and the collection is for an outstanding balance, after copayments,

deductibles, and coinsurance, owed to an emergency care provider or a facility-based provider for an out-of-network benefit claim; or

(6) creates this subdivision from existing text and makes no further changes.

(b) Defines "emergency care provider," "facility," "facility-based provider," and "health care practitioner."

ARTICLE 2. ELIMINATION OF SURPRISE BILLING FOR CERTAIN BENEFIT PLANS

SECTION 2.01. Amends Section 1271.155, Insurance Code, by amending Subsection (a) and adding Subsection (f), as follows:

(a) Requires a health maintenance organization to pay for emergency care performed by non-network physicians or providers in an amount that the organization determines is reasonable for the emergency care, rather than at the usual and customary rate, or at an agreed rate.

(f) Provides that a non-network physician or provider is prohibited from billing a patient described by this section in, and the patient has no financial responsibility for, an amount greater than the patient's responsibility under the patient's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.02. Amends Subchapter D, Chapter 1271, Insurance Code, by adding Section 1271.157, 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 a non-network provider who is a facility-based provider in an amount that the organization determines is reasonable for the service 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 a patient receiving a health care service described by Subsection (b) in, and provides that the patient does not have financial responsibility for, an amount greater than the patient's responsibility under the patient's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.03. Amends Subtitle C, Title 8, Insurance Code, by adding Chapter 1276, as follows:

CHAPTER 1276. ELECTIVE PROVISIONS FOR SELF-FUNDED OR SELF-INSURED MANAGED CARE PLANS

Sec. 1276.0001. DEFINITIONS. Defines "eligible plan," "emergency care," "facility-based provider," "managed care plan," "out-of-network provider," and "participating provider," for purposes of this section.

Sec. 1276.0002. ELECTION FOR SURPRISE HEALTH CARE BILLING PROHIBITION AND MEDIATION. (a) Authorizes a plan sponsor of an eligible plan to elect on an annual basis for this section and Chapter 1467 (Out-of-Network Claim Dispute Resolution) to apply to the plan. Requires a sponsor making an election to provide written notice of the election to the Texas Department of Insurance (TDI) in the form and manner required by TDI rule.

(b) Requires an administrator of an eligible plan for which an election is made under Subsection (a) to pay for a health care service performed by an

out-of-network provider in an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider is a facility-based provider who performed the service at a health care facility that is a participating provider or the service is emergency care.

(c) Provides that an out-of-network provider described by Subsection (b) is prohibited from billing the patient in, and the patient does not have financial responsibility for, an amount greater than the patient's responsibility under the patient's eligible plan, including an applicable copayment, coinsurance, or deductible.

(d) Requires an administrator of an eligible plan for which an election is made under Subsection (a) to ensure that the plan and any evidence of coverage complies with this section and Chapter 1467.

SECTION 2.04. Amends Section 1301.0053, Insurance Code, as follows:

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE: (a) Creates this subsection from existing text. Requires 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 in an amount that the issuer determines is reasonable for the emergency care services, rather than 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 from billing an insured receiving emergency care 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 2.05. 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 in an amount that the insurer determines is reasonable for the services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider.

(c) Provides that, for purposes of Subsection (b), an out-of-network provider, for purposes of Subsection (b), is prohibited from billing an insured in, 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 2.06. Amends Subchapter D, Chapter 1301, Insurance Code, by adding Section 1301.164, 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 by a nonpreferred provider who is a facility-based provider in an amount that the insurer determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(c) Provides that a nonpreferred provider who is a facility-based provider is prohibited from billing an insured receiving a health care service described by Subsection (b) in, and the insured does not have financial responsibility for, an

amount greater than the insured's responsibility under the insured's health care plan, including an applicable copayment, coinsurance, or deductible.

SECTION 2.07. Amends Subchapter E, Chapter 1551, Insurance Code, by adding Sections 1551.228 and 1551.229, 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 in an amount that the administrator determines is reasonable for the emergency care or at an agreed rate.

(d) Provides that an out-of-network provider, for the purposes of Subsection (c), is prohibited from billing an enrollee in, and 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. 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 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 an enrollee by an out-of-network provider who is a facility-based provider in an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(d) Provides that an out-of-network provider who is a facility-based provider is prohibited from billing an enrollee receiving a health care service described by Subsection (c) in, and 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 2.08. Amends Subchapter D, Chapter 1575, Insurance Code, by adding Section 1575.171 and 1575.172, as follows:

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

(b) Requires a managed care plan offered 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 in an amount that the administrator determines is reasonable for the emergency care or at an agreed rate.

(d) Provides that an out-of-network provider, for purposes of Subsection (c), is prohibited from billing an enrollee in, and 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 offered under the group program to provide out-of-network facility-based provider coverage 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 an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(d) Provides that an out-of-network provider who is a facility-based provider is prohibited from billing an enrollee receiving a health care service described by Subsection (c) in, and 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 2.09. Amends Subchapter C, Chapter 1579, Insurance Code, by adding Sections 1579.109 and 1579.110, 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 in an amount that the administrator determines is reasonable for the emergency care or at an agreed rate.

(d) Provides that an out-of-network provider, for the purposes of Subsection (c), is prohibited from billing an enrollee in, and 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 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 an amount that the administrator determines is reasonable for the service or at an agreed rate if the provider performed the service at a health care facility that is a participating provider.

(d) Provides that an out-of-network provider who is a facility-based provider is prohibited from billing an enrollee receiving a health care service described by Subsection (c) in, and 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 3. MANDATORY MEDIATION REQUESTED BY PROVIDER, ISSUER, OR ADMINISTRATOR

SECTION 3.01. Amends Sections 1467.001(1), (3), (5), and (7), Insurance Code, to define "administrator," "enrollee," "mediation," and "party."

SECTION 3.02. Amends Sections 1467.002 and 1467.005, Insurance Code, as follows:

Sec. 1467.002. APPLICABILITY OF CHAPTER. Provides that this chapter applies to:

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

(2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301 (Preferred Provider Benefit Plans). Creates this subdivision from existing text and redesignates existing Subdivision (2) as Subdivision (3); and

(3) an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits Program), or 1579 (Texas School Employees Uniform Group Health Coverage) or of an eligible plan for which an election is made under Section 1276.0002.

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) makes no changes to this subdivision.

SECTION 3.03. Amends Sections 1467.051(a) and (b), Insurance Code, as follows:

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

(1) the amount charged by the provider and unpaid by the issuer or administrator, after copayments, deductibles, and coinsurance, is greater than $500, 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; and

(2) Makes no changes to this subdivision.

(b) Requires the facility-based provider or emergency care provider, or the provider's representative, and the health benefit plan issuer, or the administrator, as appropriate, if a person requests mediation under this subchapter, to participate in the mediation, rather than requires 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 Subsection (c) and (d), if applicable, to participate in the mediation.

SECTION 3.04. Amends Section 1467.052(c), Insurance Code, as follows:

(c) Prohibits a person from acting as a mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business

relationship with a health benefit issuer or administrator of a health benefit plan, rather than an insurer offering the preferred provider benefit plan, that is subject to this chapter or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.

SECTION 3.05. Amends Section 1467.053(d), Insurance Code, to require the mediator's fees to be split evenly and paid by the health benefit plan issuer, rather than insurer, or administrator and the facility-based provider or emergency care provider.

SECTION 3.06. Amends Sections 1467.054(a), (b), (c), and (d), as follows:

(a) Authorizes a facility-based provider, emergency care provider, health benefit plan issuer, or administrator to request mandatory mediation under this subchapter, rather than an enrollee to request mandatory mediation under this chapter.

(b) Requires a request for mandatory mediation to be provided to TDI on a form prescribed by the commissioner of insurance and to include:

(1) the name of the person, rather than enrollee, requesting mediation;

(2) makes no changes to this subdivision;

(3)–(4) makes conforming changes to these subdivisions; and

(5) makes no changes to this subdivision.

(c) Requires TDI, on receipt of a request for mediation, to notify, as applicable, the facility-based provider or emergency care provider and health benefit plan issuer, rather than insurer, or administrator of the request.

(d) Makes conforming changes to this subsection.

SECTION 3.07. Amends Section 1467.055(g), Insurance Code, to delete an existing exception to the required date of mediation at the request of an enrollee.

SECTION 3.08. Amends Sections 1467.056(a), (b), and (d), Insurance Code, as follows:

(a) Deletes existing Subdivisions (1)–(2) and redesignates existing Paragraphs (A)–(B) as Subdivisions (1)–(2) and requires, in a mediation under this subchapter (Mandatory Mediation), rather than chapter (Out-Of-Network Claim Dispute Resolution), the parties to evaluate whether:

(1) creates this subdivision from existing text and makes no further changes; and

(2) the amount paid by the health benefit plan or administrator represents a reasonable amount for the health care or medical service or supply or is unreasonably low, rather than 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.

(b) Makes conforming changes to this subsection.

(d) Deletes existing text relating to the amount paid to the facility-based provider or emergency care provider by the enrollee and makes conforming changes to this subsection.

SECTION 3.09. Amends Sections 1467.058 and 1467.059, Insurance Code, as follows:

Sec. 1467.058. CONTINUATION OF MEDIATION. Deletes existing text relating to a provision that continuation of mediation under this section does not affect the amount of the billed charge to the enrollee and makes conforming changes to this section.

Sec. 1467.059. MEDIATION AGREEMENT. Deletes existing text relating to the total amount for which the enrollee will be responsible to the facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance and makes nonsubstantive changes to this section.

SECTION 3.10. Amends Sections 1467.101(a), Insurance Code, to provide that certain actions including failing to appear for mediation, constitutes bad faith mediation for purposes of this chapter.

SECTION 2.11. Amends Sections 1467.151(b), Insurance Code, to require TDI and the Texas Medical Board or other appropriate regulatory agency to maintain certain information, including information related to a claim that is the basis of an enrollee complaint, including any other information about the health benefit plan issuer, rather than insurer, or administrator that the commissioner of insurance by rule requires.

ARTICLE 4. CONFORMING AMENDMENTS

SECTION 4.01. Amends Sections 1456.002(a) and (c), Insurance Code, as follows:

(a) Deletes existing text providing that this chapter 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 1271.155 (Emergency Care), 1301.164, 1551.229, 1575.172, or 1579.110, or an eligible plan for which an election is made under Section 1276.0002 and makes nonsubstantive changes to this subsection.

SECTION 4.02. Repealer: Section 1467.051(c) (relating to a requirement of a facility-based provider to 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 1467.0511 (Notice and Information Provided to Enrollee), Insurance Code.

Repealer: Section 1467.054(f) (relating to authorizing the enrollee to elect to participate in the mediation), Insurance Code.

Repealer: Section 1467.054(g) (relating to authorizing mediation to proceed without the participation of the enrollee or the enrollee's representative if the enrollee or representative is not present in person or through teleconference), Insurance Code.

Repealer: Section 1467.055(d) (relating to authorizing an enrollee to file a complaint if the enrollee is not satisfied with the mediated agreement), 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 disclosure is not subject to discipline), Insurance Code.

ARTICLE 5. TRANSITION AND EFFECTIVE DATE

SECTION 5.01. Makes application of this Act prospective.

SECTION 4.02. Effective date: September 1, 2019.