

1 AN ACT

2 relating to the mediation of the settlement of certain health
3 benefit claims involving balance billing by out-of-network
4 laboratories.

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

6 SECTION 1. Section 1467.001, Insurance Code, is amended by
7 amending Subdivisions (4), (5), and (7) and adding Subdivisions
8 (4-b) and (4-c) to read as follows:

9 (4) "Facility-based provider" means a physician,
10 health care practitioner, or other health care provider who
11 provides health care [~~or medical~~] services to patients of a
12 facility.

13 (4-b) "Health care services" has the meaning assigned
14 by Section 562.002.

15 (4-c) "Laboratory" means an accredited facility in
16 which a specimen taken from a human body is interpreted and
17 pathological diagnoses are made.

18 (5) "Mediation" means a process in which an impartial
19 mediator facilitates and promotes agreement between the insurer
20 offering a preferred provider benefit plan or the administrator and
21 a laboratory, facility-based provider, or emergency care provider
22 or the laboratory's or provider's representative to settle a health
23 benefit claim of an enrollee.

24 (7) "Party" means an insurer offering a preferred

1 provider benefit plan, an administrator, or a laboratory,
2 facility-based provider, or emergency care provider or the
3 laboratory's or provider's representative who participates in a
4 mediation conducted under this chapter. The enrollee is also
5 considered a party to the mediation.

6 SECTION 2. Section 1467.005, Insurance Code, is amended to
7 read as follows:

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

10 (1) an insurer offering a preferred provider benefit
11 plan or administrator from, at any time, offering a reformed claim
12 settlement; or

13 (2) a laboratory, facility-based provider, or
14 emergency care provider from, at any time, offering a reformed
15 charge for health care [~~or medical~~] services [~~or supplies~~].

16 SECTION 3. Section 1467.051, Insurance Code, is amended to
17 read as follows:

18 Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION;
19 EXCEPTION. (a) An enrollee may request mediation of a settlement
20 of an out-of-network health benefit claim if:

21 (1) the amount for which the enrollee is responsible
22 to a laboratory, facility-based provider, or emergency care
23 provider, after copayments, deductibles, and coinsurance,
24 including the amount unpaid by the administrator or insurer, is
25 greater than \$500; and

26 (2) the health benefit claim is for:

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

1 (B) a health care [~~or medical~~] service [~~or~~
2 ~~supply~~] provided by a facility-based provider in a facility that is
3 a preferred provider or that has a contract with the administrator;
4 or

5 (C) a laboratory service, if:

6 (i) the specimen evaluated by the
7 laboratory is collected:

8 (a) at the office of a health care
9 practitioner who is a preferred provider or has a contract with the
10 administrator; or

11 (b) at a facility that is a preferred
12 provider or that has a contract with the administrator; and

13 (ii) the laboratory is an out-of-network
14 laboratory.

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

20 (c) Except in the case of an emergency and if requested by
21 the enrollee, a laboratory or facility-based provider shall, before
22 providing a health care [~~or medical~~] service [~~or supply~~], provide a
23 complete disclosure to an enrollee that:

24 (1) explains that the laboratory or facility-based
25 provider does not have a contract with the enrollee's health
26 benefit plan;

27 (2) discloses projected amounts for which the enrollee

1 may be responsible; and

2 (3) discloses the circumstances under which the
3 enrollee would be responsible for those amounts.

4 (d) A laboratory or facility-based provider who makes a
5 disclosure under Subsection (c) and obtains the enrollee's written
6 acknowledgment of that disclosure may not be required to mediate a
7 billed charge under this subchapter if the amount billed is less
8 than or equal to the maximum amount projected in the disclosure.

9 SECTION 4. Section 1467.0511, Insurance Code, is amended to
10 read as follows:

11 Sec. 1467.0511. NOTICE AND INFORMATION PROVIDED TO
12 ENROLLEE. (a) A bill sent to an enrollee by a laboratory,
13 facility-based provider, or emergency care provider or an
14 explanation of benefits sent to an enrollee by an insurer or
15 administrator for an out-of-network health benefit claim eligible
16 for mediation under this chapter must contain, in not less than
17 10-point boldface type, a conspicuous, plain-language explanation
18 of the mediation process available under this chapter, including
19 information on how to request mediation and a statement that is
20 substantially similar to the following:

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

25 (b) If an enrollee contacts an insurer, administrator,
26 laboratory, facility-based provider, or emergency care provider
27 about a bill that may be eligible for mediation under this chapter,

1 the insurer, administrator, laboratory, facility-based provider,
2 or emergency care provider is encouraged to:

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

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

7 SECTION 5. Section 1467.052(c), Insurance Code, is amended
8 to read as follows:

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

15 SECTION 6. Section 1467.053(d), Insurance Code, is amended
16 to read as follows:

17 (d) The mediator's fees shall be split evenly and paid by
18 the insurer or administrator and the laboratory, facility-based
19 provider, or emergency care provider.

20 SECTION 7. Sections 1467.054(b), (c), and (e), Insurance
21 Code, are amended to read as follows:

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

- 25 (1) the name of the enrollee requesting mediation;
26 (2) a brief description of the claim to be mediated;
27 (3) contact information, including a telephone

1 number, for the requesting enrollee and the enrollee's counsel, if
2 the enrollee retains counsel;

3 (4) the name of the laboratory, facility-based
4 provider, or emergency care provider and name of the insurer or
5 administrator; and

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

8 (c) On receipt of a request for mediation, the department
9 shall notify the laboratory, facility-based provider, or emergency
10 care provider and insurer or administrator of the request.

11 (e) A dispute to be mediated under this chapter that does
12 not settle as a result of a teleconference conducted under
13 Subsection (d) must be conducted in the county in which the health
14 care [~~or medical~~] services were rendered.

15 SECTION 8. Sections 1467.055(d), (h), and (i), Insurance
16 Code, are amended to read as follows:

17 (d) If the enrollee is participating in the mediation in
18 person, at the beginning of the mediation the mediator shall inform
19 the enrollee that if the enrollee is not satisfied with the mediated
20 agreement, the enrollee may file a complaint with:

21 (1) the Texas Medical Board or other appropriate
22 regulatory agency against the laboratory, facility-based provider,
23 or emergency care provider for improper billing; and

24 (2) the department for unfair claim settlement
25 practices.

26 (h) On receipt of notice from the department that an
27 enrollee has made a request for mediation that meets the

1 requirements of this chapter, the laboratory, facility-based
2 provider, or emergency care provider may not pursue any collection
3 effort against the enrollee who has requested mediation for amounts
4 other than copayments, deductibles, and coinsurance before the
5 earlier of:

- 6 (1) the date the mediation is completed; or
- 7 (2) the date the request to mediate is withdrawn.

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

13 SECTION 9. Sections 1467.056(a), (b), and (d), Insurance
14 Code, are amended to read as follows:

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

- 16 (1) evaluate whether:
 - 17 (A) the amount charged by the laboratory,
 - 18 facility-based provider, or emergency care provider for the health
 - 19 care [~~or medical~~] service [~~or supply~~] is excessive; and
 - 20 (B) the amount paid by the insurer or
 - 21 administrator represents the usual and customary rate for the
 - 22 health care [~~or medical~~] service [~~or supply~~] or is unreasonably
 - 23 low; and

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

1 emergency care provider.

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

7 (d) The goal of the mediation is to reach an agreement among
8 the enrollee, the laboratory, facility-based provider, or
9 emergency care provider, and the insurer or administrator, as
10 applicable, as to the amount paid by the insurer or administrator to
11 the laboratory, facility-based provider, or emergency care
12 provider, the amount charged by the laboratory, facility-based
13 provider, or emergency care provider, and the amount paid to the
14 laboratory, facility-based provider, or emergency care provider by
15 the enrollee.

16 SECTION 10. Section 1467.058, Insurance Code, is amended to
17 read as follows:

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

25 SECTION 11. Section 1467.059, Insurance Code, is amended to
26 read as follows:

27 Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall

1 prepare a confidential mediation agreement and order that states:

2 (1) the total amount for which the enrollee will be
3 responsible to the laboratory, facility-based provider, or
4 emergency care provider, after copayments, deductibles, and
5 coinsurance; and

6 (2) any agreement reached by the parties under Section
7 1467.058.

8 SECTION 12. Sections 1467.151(a), (b), and (d), Insurance
9 Code, are amended to read as follows:

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

16 (1) distinguish among complaints for out-of-network
17 coverage or payment and give priority to investigating allegations
18 of delayed health care services [~~or medical care~~];

19 (2) develop a form for filing a complaint and
20 establish an outreach effort to inform enrollees of the
21 availability of the claims dispute resolution process under this
22 chapter;

23 (3) ensure that a complaint is not dismissed without
24 appropriate consideration;

25 (4) ensure that enrollees are informed of the
26 availability of mandatory mediation; and

27 (5) require the administrator to include a notice of

1 the claims dispute resolution process available under this chapter
2 with the explanation of benefits sent to an enrollee.

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

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

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

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

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

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

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

18 (E) any other information about:

19 (i) the insurer or administrator that the
20 commissioner by rule requires; or

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

24 (d) A laboratory, facility-based provider, or emergency
25 care provider who fails to provide a disclosure under Section
26 1467.051 or 1467.0511 is not subject to discipline by the Texas
27 Medical Board or other appropriate regulatory agency for that

1 failure and a cause of action is not created by a failure to
2 disclose as required by Section 1467.051 or 1467.0511.

3 SECTION 13. The changes in law made by this Act apply only
4 to a claim for health care services provided on or after September
5 1, 2019. A claim for health care services provided before September
6 1, 2019, is governed by the law as it existed immediately before the
7 effective date of this Act, and that law is continued in effect for
8 that purpose.

9 SECTION 14. This Act takes effect only if none of the
10 following bills proposed by the 86th Legislature, Regular Session,
11 2019, or similar legislation of the 86th Legislature, Regular
12 Session, 2019, are enacted and become law:

13 (1) H.B. 2967, relating to prohibited balance billing
14 and an independent dispute resolution program for out-of-network
15 coverage under certain managed care plans;

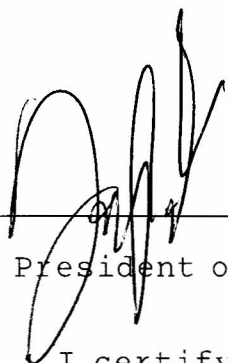
16 (2) H.B. 3933, relating to consumer protections
17 against billing and limitations on information reported by consumer
18 reporting agencies;

19 (3) S.B. 1264, relating to consumer protections
20 against certain medical and health care billing by certain
21 out-of-network providers; or

22 (4) S.B. 1591, relating to prohibited balance billing
23 and an independent dispute resolution program for out-of-network
24 coverage under certain managed care plans.

25 SECTION 15. This Act takes effect September 1, 2019.

H.B. No. 1742



President of the Senate



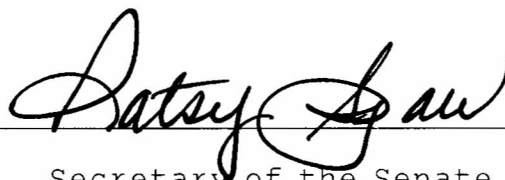
Speaker of the House

I certify that H.B. No. 1742 was passed by the House on April 26, 2019, by the following vote: Yeas 139, Nays 0, 2 present, not voting; and that the House concurred in Senate amendments to H.B. No. 1742 on May 24, 2019, by the following vote: Yeas 142, Nays 0, 2 present, not voting.



Chief Clerk of the House

I certify that H.B. No. 1742 was passed by the Senate, with amendments, on May 22, 2019, by the following vote: Yeas 31, Nays 0.



Secretary of the Senate

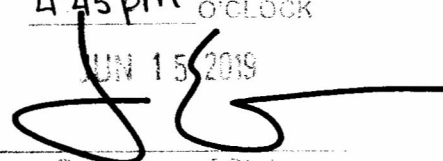
APPROVED: _____

Date

Governor

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
4:45 pm O'CLOCK

JUN 15 2019



Secretary of State

PROCLAMATION
BY THE
Governor of the State of Texas
41-3651

TO ALL TO WHOM THESE PRESENTS SHALL COME:

Pursuant to Article IV, Section 14, of the Texas Constitution, I, Greg Abbott, Governor of Texas, do hereby disapprove of and veto House Bill No. 1742 as passed by the Eighty-Sixth Texas Legislature, Regular Session, because of the following objections:

In an effort to end surprise medical billing in Texas, I have signed Senate Bill 1264 into law. That leaves no work to be done by House Bill 1742, as the bill itself acknowledges in Section 14. I applaud the Legislature for addressing this critical issue in a number of bills, and I am proud to have signed the broadest one that reached my desk.

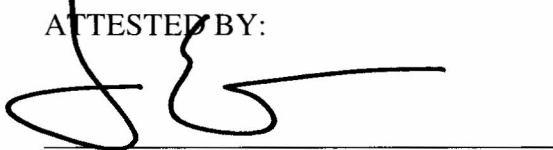
Since the Eighty-Sixth Texas Legislature, Regular Session, by its adjournment has prevented the return of this bill, I am filing these objections in the office of the Secretary of State and giving notice thereof by this public proclamation according to the aforementioned constitutional provision.



IN TESTIMONY WHEREOF, I have signed my name officially and caused the Seal of the State to be affixed hereto at Austin, this 15th day of June, 2019.


GREG ABBOTT
Governor of Texas

ATTESTED BY:


JOE ESPARZA
Deputy Secretary of State

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
4:45pm O'CLOCK

JUN 15 2019