AN ACT

relating to mediation of out-of-network health benefit claim disputes concerning enrollees, facility-based physicians, and certain health benefit plans; imposing an administrative penalty.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1467 to read as follows:

CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1467.001. DEFINITIONS. In this chapter:

(1) "Administrator" means:

(A) an administering firm for a health benefit plan providing coverage under Chapter 1551; and

(B) if applicable, the claims administrator for the health benefit plan.

(2) "Chief administrative law judge" means the chief administrative law judge of the State Office of Administrative Hearings.

(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.

(4) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

(A) to whom the facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

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

(6) "Mediator" means an impartial person who is appointed to conduct a mediation under this chapter.

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

Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter applies 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.

Sec. 1467.003. RULES. The commissioner, the Texas Medical Board, and the chief administrative law judge shall adopt rules as necessary to implement their respective powers and duties under this chapter.

Sec. 1467.004. REMEDIES NOT EXCLUSIVE. The remedies

provided by this chapter are in addition to any other defense, remedy, or procedure provided by law, including the common law.

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 physician from, at any time, offering a reformed charge for medical services.

[Sections 1467.006-1467.050 reserved for expansion]

SUBCHAPTER B. MANDATORY MEDIATION

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION; EXCEPTION. (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 physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000; and

(2) the health benefit claim is for a medical service or supply provided by a facility-based physician in a hospital 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 physician or the physician's representative and the insurer or the administrator, as appropriate, shall participate in the mediation.

(c) Except in the case of an emergency and if requested by the enrollee, a facility-based physician shall, before providing a medical service or supply, provide a complete disclosure to an enrollee that:

(1) explains that the facility-based physician does not have a contract with the enrollee's health benefit plan;

(2) discloses projected amounts for which the enrollee may be responsible; and

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

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

Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Except as provided by Subsection (b), to qualify for an appointment as a mediator under this chapter a person must have completed at least 40 classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the chief administrative law judge.

(b) A person not qualified under Subsection (a) may be appointed as a mediator on agreement of the parties.

(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 during the three years immediately preceding the request for mediation.

Sec. 1467.053. APPOINTMENT OF MEDIATOR; FEES. (a) A mediation shall be conducted by one mediator.

(b) The chief administrative law judge shall appoint the mediator through a random assignment from a list of qualified mediators maintained by the State Office of Administrative Hearings.

(c) Notwithstanding Subsection (b), a person other than a mediator appointed by the chief administrative law judge may conduct the mediation on agreement of all of the parties and notice to the chief administrative law judge.

(d) The mediator's fees shall be split evenly and paid by the insurer or administrator and the facility-based physician.

Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR MANDATORY MEDIATION. (a) An enrollee may request mandatory mediation under this chapter.

(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 physician 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 physician and insurer or administrator of the request.

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

(e) A dispute to be mediated under this chapter that does not settle as a result of a teleconference conducted under Subsection (d) must be conducted in the county in which the medical services were rendered.

(f) The enrollee may elect to participate in the mediation. A mediation may not proceed without the consent of the enrollee. An enrollee may withdraw the request for mediation at any time before the mediation.

(g) Notwithstanding Subsection (f), mediation may 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.

Sec. 1467.055. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a) A mediator may not impose the mediator's judgment on a party about an issue that is a subject of the mediation.

(b) A mediation session is under the control of the mediator.

(c) Except as provided by this chapter, the mediator must

hold in strict confidence all information provided to the mediator by a party and all communications of the mediator with a party.

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

(1) the Texas Medical Board against the facility-based physician for improper billing; and

(2) the department for unfair claim settlement practices.

(e) A party must have an opportunity during the mediation to speak and state the party's position.

(f) Except on the agreement of the participating parties, a mediation may not last more than four hours.

(g) Except at the request of an enrollee, a mediation shall be held not later than the 180th day after the date of the request for mediation.

(h) On receipt of notice from the department that an enrollee has made a request for mediation that meets the requirements of this chapter, the facility-based physician may not pursue any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and coinsurance before the earlier of:

(1) the date the mediation is completed; or

(2) the date the request to mediate is withdrawn.

(i) A service provided by a facility-based physician may not be summarily disallowed. This subsection does not require an

insurer or administrator to pay for an uncovered service.

(j) A mediator may not testify in a proceeding, other than a proceeding to enforce this chapter, related to the mediation agreement.

Sec. 1467.056. MATTERS CONSIDERED IN MEDIATION; AGREED RESOLUTION. (a) In a mediation under this chapter, the parties shall:

(1) evaluate whether:

(A) the amount charged by the facility-based physician for the medical service or supply is excessive; and

(B) the amount paid by the insurer or administrator represents the usual and customary rate for the 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 physician.

(b) The facility-based physician may present information regarding the amount charged for the medical service or supply. The insurer or administrator may present information regarding the amount paid by the insurer.

(c) Nothing in this chapter prohibits mediation of more than one claim between the parties during a mediation.

(d) The goal of the mediation is to reach an agreement among the enrollee, the facility-based physician, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based physician, the amount

charged by the facility-based physician, and the amount paid to the facility-based physician by the enrollee.

Sec. 1467.057. NO AGREED RESOLUTION. (a) The mediator of an unsuccessful mediation under this chapter shall report the outcome of the mediation to the department, the Texas Medical Board, and the chief administrative law judge.

(b) The chief administrative law judge shall enter an order of referral of a matter reported under Subsection (a) to a special judge under Chapter 151, Civil Practice and Remedies Code, that:

(1) names the special judge on whom the parties agreed or appoints the special judge if the parties did not agree on a judge;

(2) states the issues to be referred and the time and place on which the parties agree for the trial;

(3) requires each party to pay the party's proportionate share of the special judge's fee; and

(4) certifies that the parties have waived the right to trial by jury.

(c) A trial by the special judge selected or appointed as described by Subsection (b) must proceed under Chapter 151, Civil Practice and Remedies Code, except that the special judge's verdict is not relevant or material to any other balance bill dispute and has no precedential value.

(d) Notwithstanding any other provision of this section, Section 151.012, Civil Practice and Remedies Code, does not apply to a mediation under this chapter.

Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral

is made under Section 1467.057, the facility-based physician 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.

Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall prepare a confidential mediation agreement and order that states:

(1) the total amount for which the enrollee will be responsible to the facility-based physician, after copayments, deductibles, and coinsurance; and

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

Sec. 1467.060. REPORT OF MEDIATOR. The mediator shall report to the commissioner and the Texas Medical Board:

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

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

[Sections 1467.061-1467.100 reserved for expansion]

SUBCHAPTER C. BAD FAITH MEDIATION

Sec. 1467.101. BAD FAITH. (a) The following conduct constitutes bad faith mediation for purposes of this chapter:

(1) failing to participate in the mediation;

(2) failing to provide information the mediator believes is necessary to facilitate an agreement; or

(3) failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement.

(b) Failure to reach an agreement is not conclusive proof of bad faith mediation.

(c) A mediator shall report bad faith mediation to the commissioner or the Texas Medical Board, as appropriate, following the conclusion of the mediation.

Sec. 1467.102. PENALTIES. (a) Bad faith mediation, by a party other than the enrollee, 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.

(b) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith mediation, the regulatory agency that issued the license or certificate of authority shall impose an administrative penalty.

[Sections 1467.103-1467.150 reserved for expansion]

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The commissioner and the Texas Medical Board, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. The rules adopted under this section must:

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

(2) 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;

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

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

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

(b) The department and the Texas Medical Board 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 of the facility-based physician who provided the out-of-network service;

(C) the county and metropolitan area in which the medical service or supply was provided;

(D) whether the 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 physician that the Texas Medical

Board by rule requires.

(c) The information collected and maintained by the department and the Texas Medical Board under Subsection (b)(2) is public information as defined by Section 552.002, Government Code, and may not include personally identifiable information or medical information.

(d) A facility-based physician who fails to provide a disclosure under Section 1467.051 is not subject to discipline by the Texas Medical Board for that failure and a cause of action is not created by a failure to disclose as required by Section 1467.051.

SECTION 2. Subchapter A, Chapter 1301, Insurance Code, is amended by adding Section 1301.0055 to read as follows:

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. The commissioner shall by rule adopt network adequacy standards that:

(1) are adapted to local markets in which an insurer offering a preferred provider benefit plan operates;

(2) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health care services to insureds; and

(3) on good cause shown, may allow departure from local market network adequacy standards if the commissioner posts on the department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market.

SECTION 3. Section 1456.004, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) A facility-based physician who bills a patient covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551 that does not have a contract with the facility-based physician shall send a billing statement to the patient with information sufficient to notify the patient of the mandatory mediation process available under Chapter 1467 if the amount for which the enrollee is responsible, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000.

SECTION 4. Section 324.001, Health and Safety Code, is amended by adding Subsection (8) to read as follows:

(8) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist.

SECTION 5. Section 324.101(a), Health and Safety Code, is amended to read as follows:

(a) Each facility shall develop, implement, and enforce written policies for the billing of facility health care services and supplies. The policies must address:

(1) any discounting of facility charges to an uninsured consumer, subject to Chapter 552, Insurance Code;

(2) any discounting of facility charges provided to a financially or medically indigent consumer who qualifies for indigent services based on a sliding fee scale or a written charity care policy established by the facility and the documented income and other resources of the consumer;

(3) the providing of an itemized statement required by

Subsection (e);

(4) whether interest will be applied to any billed service not covered by a third-party payor and the rate of any interest charged;

(5) the procedure for handling complaints; [~~and~~]

(6) the providing of a conspicuous written disclosure to a consumer at the time the consumer is first admitted to the facility or first receives services at the facility that:

(A) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided; [~~and~~]

(B) informs consumers [~~the consumer~~] that a facility-based physician [~~or other health care provider~~] who may provide services to the consumer while the consumer is in the facility may not be a participating provider with the same third-party payors as the facility;

(C) informs consumers that the consumer may receive a bill for medical services from a facility-based physician for the amount unpaid by the consumer's health benefit plan;

(D) informs consumers that the consumer may request a listing of facility-based physicians who have been granted medical staff privileges to provide medical services at the facility; and

(E) informs consumers that the consumer may request information from a facility-based physician on whether the

physician has a contract with the consumer's health benefit plan and under what circumstances the consumer may be responsible for payment of any amounts not paid by the consumer's health benefit plan;

(7) the requirement that a facility provide a list, on request, to a consumer to be admitted to, or who is expected to receive services from, the facility, that contains the name and contact information for each facility-based physician or facility-based physician group that has been granted medical staff privileges to provide medical services at the facility; and

(8) if the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, the posting on the facility's website of a list that contains the name and contact information for each facility-based physician or facility-based physician group that has been granted medical staff privileges to provide medical services at the facility and the updating of the list in any calendar quarter in which there are any changes to the list.

SECTION 6. (a) Except as provided by Subsection (b), this Act applies only to a health benefit claim filed on or after the effective date of this Act. A claim filed before the effective date of this Act 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.

(b) Section 1467.002(2), Insurance Code, as added by this Act, applies to a health benefit claim filed under a group policy or

contract executed under Chapter 1551, Insurance Code, on or after September 1, 2010. A claim filed under a group policy or contract executed under Chapter 1551, Insurance Code, before September 1, 2010, is governed by the law as it existed immediately before September 1, 2010, and that law is continued in effect for that purpose.

SECTION 7. As soon as practicable after the effective date of this Act, the commissioner of insurance, Texas Medical Board, and chief administrative law judge of the State Office of Administrative Hearings shall adopt rules as necessary to implement and enforce this Act.

SECTION 8. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.

President of the Senate

Speaker of the House

I certify that H.B. No. 2256 was passed by the House on May 11, 2009, by the following vote: Yeas 139, Nays 2, 3 present, not voting; and that the House concurred in Senate amendments to H.B. No. 2256 on May 29, 2009, by the following vote: Yeas 136, Nays 1, 4 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 2256 was passed by the Senate, with amendments, on May 27, 2009, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor