BILL ANALYSIS

C.S.H.B. 1566
By: Frullo
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties have expressed concerns with eligibility restrictions on the availability of mandatory mediation as a method for resolving billing disputes regarding certain health benefit claims. C.S.H.B. 1566 seeks to address this concern by allowing more consumers to utilize mediation as a method for resolving such issues.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1566 amends the Insurance Code to apply statutory provisions relating to out-of-network health benefit claim dispute resolution to an administrator of a health benefit plan, other than a health maintenance organization plan, under the Texas Public School Retired Employees Group Benefits Act or the Texas School Employees Uniform Group Health Coverage Act. The bill replaces references to a facility-based physician in those statutory provisions with references to a facility-based provider, defined by the bill as a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility. The bill includes references to an emergency care provider, health care services, and supplies in certain of those statutory provisions, as appropriate. The bill makes specified duties and responsibilities of the Texas Medical Board and certain other entities provided under such statutory provisions applicable to any other appropriate regulatory agency, including the requirement to adopt rules as necessary to implement the respective agency's powers and duties.

C.S.H.B. 1566 requires 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 to contain, in not less than 10-point boldface type, a conspicuous, plain-language explanation of the mediation process. The bill establishes that an insurer, administrator, facility-based provider, or emergency care provider is encouraged to inform an enrollee who contacts the insurer, administrator or provider about a bill that may be eligible for mediation about that mediation and to provide the enrollee with the Texas Department of Insurance's toll-free telephone number and website address. The bill establishes that a facility-based provider or emergency care provider who fails to provide a disclosure as required by these provisions is not subject to discipline by the board or other appropriate regulatory agency for that failure and also establishes that a cause of action is not created by that failure to disclose.

C.S.H.B. 1566 includes among the persons prohibited from acting as a mediator for a claim settlement dispute a person who has been employed by, consulted for, or otherwise had a business relationship with a health care practitioner or other health care provider during the three years immediately preceding the request for mediation. The bill repeals a provision requiring a mediator to report bad faith mediation to the insurance commissioner or the board, as appropriate, following the conclusion of the mediation. The bill applies only to a claim for health care or medical services or supplies provided on or after January 1, 2018.

C.S.H.B. 1566 repeals Section 1467.101(c), Insurance Code.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1566 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 1467.001, Insurance Code, is amended by amending Subdivisions (1), (3), (4), (5), and (7) and adding Subdivisions (2-a), (3-a), and (4-a) to read as follows:	SECTION 1. Section 1467.001, Insurance Code, is amended by amending Subdivisions (1), (3), (4), (5), and (7) and adding Subdivisions (2-a), (2-b), (3-a), and (4-a) to read as follows:
(1) "Administrator" means:	(1) "Administrator" means:
(A) an administering firm for a health benefit plan providing coverage under Chapter 1551, 1575, or 1579; and	(A) an administering firm for a health benefit plan providing coverage under Chapter 1551, 1575, or 1579; and
(B) if applicable, the claims administrator for the health benefit plan.	(B) if applicable, the claims administrator for the health benefit plan.
	(2-a) "Emergency care" has the meaning assigned by Section 1301.155.
(2-a) "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.	(2-b) "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.
(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.	(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.
(3-a) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.	(3-a) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.
(4) "Facility-based provider [~~physician~~]" means a physician, health care practitioner, or other health care provider [~~radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon:~~	(4) "Facility-based provider [~~physician~~]" means a physician, health care practitioner, or other health care provider [~~radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon:~~

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

[~~(B)~~] who provides health care or medical services to patients of a [~~the~~] facility [~~under those clinical privileges~~].

(4-a) "Health care practitioner" means an individual who is licensed to provide health care services.

(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 provider or emergency care provider [~~physician~~] or the provider's [~~physician's~~] representative to settle a health benefit claim of an enrollee.

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

SECTION 2. Section 1467.002, Insurance Code, is amended.

SECTION 3. Section 1467.003, Insurance Code, is amended.

SECTION 4. 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 [~~physician~~] from, at any time, offering a reformed charge for health care or medical services.

SECTION 5. Section 1467.051, Insurance Code, is amended to read as follows:

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 provider or

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

[~~(B)~~] who provides health care or medical services to patients of a [~~the~~] facility [~~under those clinical privileges~~].

(4-a) "Health care practitioner" means an individual who is licensed to provide health care services.

(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 provider or emergency care provider [~~physician~~] or the provider's [~~physician's~~] representative to settle a health benefit claim of an enrollee.

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

SECTION 2. Same as introduced version.

SECTION 3. Same as introduced version.

SECTION 4. 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 [~~physician~~] from, at any time, offering a reformed charge for health care or medical services or supplies.

SECTION 5. Section 1467.051, Insurance Code, is amended to read as follows:

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION; EXCEPTION.

(a) Same as introduced version.

emergency care provider [~~physician~~], 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 [~~physician~~] in a facility [~~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 provider or emergency care provider, [~~physician~~] or the provider's [~~physician's~~] representative, and the insurer or the administrator, as appropriate, shall participate in the mediation.

(b) Same as introduced version.

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

(1) explains that the facility-based provider [~~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.

(c) Same as introduced version.

(d) A facility-based provider [~~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.

(d) Same as introduced version.

SECTION 6. Subchapter B, Chapter 1467, Insurance Code, is amended by adding Section 1467.0511 to read as follows:

Sec. 1467.0511. NOTICE AND INFORMATION PROVIDED TO ENROLLEE.

(e) A bill sent to an enrollee by a facility-based provider or emergency care provider 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-

(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

language explanation of the mediation process available under this chapter, including information on how to request mediation and a statement substantially similar to the following: "This statement is a balance bill for out-of-network services that may be eligible for mediation. You may obtain more information at www.tdi.texas.gov/consumer/cpmmediation.html."	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)."
No equivalent provision.	(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 6. Section 1467.052(c), Insurance Code, is amended.	SECTION 7. Same as introduced version.
SECTION 7. Section 1467.053(d), Insurance Code, is amended.	SECTION 8. Same as introduced version.
SECTION 8. Sections 1467.054(b), (c), (d), and (e), 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 [~~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 provider or emergency care provider	SECTION 9. Sections 1467.054(b), (c), and (e), Insurance Code, are amended to read as follows: (b) Same as introduced version. (c) Same as introduced version.

[~~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 unless otherwise agreed by all parties. The facility-based provider or emergency care provider and the insurer or administrator are equally responsible for scheduling the informal settlement teleconference.

No equivalent provision.

(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 health care or medical services were rendered.

(e) Same as introduced version.

SECTION 9. Sections 1467.055(d), (g), (h), and (i), Insurance Code, are amended to read as follows:

SECTION 10. Sections 1467.055(d), (h), and (i), Insurance Code, are amended to read as follows:

(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:

(d) Same as introduced version.

(1) the Texas Medical Board or other appropriate regulatory agency against the facility-based provider or emergency care provider [~~physician~~] for improper billing; and

(2) the department for unfair claim settlement practices.

(g) Except at the request of an enrollee or as otherwise agreed by all parties, a mediation shall be held not later than the 180th day after the date of the request for mediation.

No equivalent provision.

(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 provider or emergency care provider [~~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:

(h) Same as introduced version.

(1) the date the mediation is completed; or

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

(i) A health care or medical service

(i) A health care or medical service or

provided by a facility-based provider or emergency care provider [~~physician~~] may not be summarily disallowed. This subsection does not require an insurer or administrator to pay for an uncovered service.	supply provided by a facility-based provider or emergency care provider [~~physician~~] may not be summarily disallowed. This subsection does not require an insurer or administrator to pay for an uncovered service or supply.
SECTION 10. Sections 1467.056(a), (b), and (d), Insurance Code, are amended.	SECTION 11. Same as introduced version.
SECTION 11. Section 1467.057(a), Insurance Code, is amended.	SECTION 12. Same as introduced version.
SECTION 12. Section 1467.058, Insurance Code, is amended.	SECTION 13. Same as introduced version.
SECTION 13. Section 1467.059, Insurance Code, is amended.	SECTION 14. Same as introduced version.
SECTION 14. Section 1467.060, Insurance Code, is amended.	SECTION 15. Same as introduced version.
SECTION 15. Section 1467.101(c), Insurance Code, is amended to read as follows: (c) A mediator shall report bad faith mediation to the commissioner or the Texas Medical Board or other regulatory agency, as appropriate, following the conclusion of the mediation.	SECTION 17. Section 1467.101(c), Insurance Code, is repealed.
SECTION 16. Section 1467.151, Insurance Code, is amended to read as follows: Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The commissioner and the Texas Medical Board or other regulatory agency, 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 health care or 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	SECTION 16. Section 1467.151, Insurance Code, is amended to read as follows: Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) Same as introduced version.

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 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 [~~physician~~] 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 [~~physician~~] that the Texas Medical Board or other appropriate regulatory agency by rule requires.

(c) The information collected and maintained by the department and the Texas Medical Board 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.

(d) A facility-based provider or emergency care provider [~~physician~~] who fails to provide a disclosure under Section 1467.051 is not subject to discipline by the Texas Medical Board or other appropriate regulatory agency for that failure and a cause of action is not created by a failure to disclose as required by Section 1467.051.

SECTION 17. The changes in law made by this Act apply only to a claim for health care or medical services provided on or after

(b) Same as introduced version.

(c) Same as introduced version.

(d) A facility-based provider or emergency care provider [~~physician~~] who fails to provide a disclosure under Section 1467.051 or 1467.0511 is not subject to discipline by the Texas Medical Board or other appropriate regulatory agency for that failure and a cause of action is not created by a failure to disclose as required by Section 1467.051 or 1467.0511.

SECTION 18. The changes in law made by this Act apply only to a claim for health care or medical services or supplies provided on

January 1, 2018. A claim for health care or medical services provided before January 1, 2018, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 18. This Act takes effect September 1, 2017.

or after January 1, 2018. A claim for health care or medical services or supplies provided before January 1, 2018, is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 19. Same as introduced version.