By: Hancock S.B. No. 507

(In the Senate - Filed January 17, 2017; February 6, 2017, read first time and referred to Committee on Business & Commerce; March 16, 2017, reported adversely, with favorable Committee Substitute by the following vote: Yeas 8, Nays 1; March 16, 2017, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Hancock	X			
Creighton	X			
Campbell		X		
Estes	X			
Nichols	X			
Schwertner	X			
Taylor of Galveston	X			
Whitmire	X			
Zaffirini	X			

COMMITTEE SUBSTITUTE FOR S.B. No. 507 By: Hancock

A BILL TO BE ENTITLED
AN ACT

relating to mediation of the settlement of certain out-of-network health benefit claims involving balance billing.

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

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:

(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.

(2-a) "Emergency care" has the meaning assigned by Section 1301.155.

(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-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:~~

[~~(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 to read as follows:

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, 1575, or 1579.

SECTION 3. Section 1467.003, Insurance Code, is amended to read as follows:

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

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) 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 [~~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.

(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.

(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.

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. (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 7. 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 8. 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 [~~physician~~].

SECTION 9. Sections 1467.054(b), (c), 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 [~~physician~~] and insurer or administrator of the request.

(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.

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:

(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.

(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:

(1) the date the mediation is completed; or

(2) the date the request to mediate is withdrawn.

(i) A health care or medical service or 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 11. 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 [~~physician~~] 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 [~~physician~~].

(b) The facility-based provider or emergency care provider [~~physician~~] 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 [~~physician~~], 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 [~~physician~~], the amount charged by the facility-based provider or emergency care provider [~~physician~~], and the amount paid to the facility-based provider or emergency care provider [~~physician~~] by the enrollee.

SECTION 12. Section 1467.057(a), Insurance Code, is amended to read as follows:

(a) The mediator of an unsuccessful mediation under this chapter shall report the outcome of the mediation to the department, the Texas Medical Board or other appropriate regulatory agency, and the chief administrative law judge.

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 [~~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.

SECTION 14. Section 1467.059, Insurance Code, is amended to read as follows:

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 provider or emergency care provider [~~physician~~], after copayments, deductibles, and coinsurance; and

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

SECTION 15. Section 1467.060, Insurance Code, is amended to read as follows:

Sec. 1467.060. REPORT OF MEDIATOR. The mediator shall report to the commissioner and the Texas Medical Board or other appropriate regulatory agency:

(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.

SECTION 16. 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 1467.151, 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 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 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 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. This Act takes effect September 1, 2017.

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