Amend **SB 418** as follows:

(1) Strike SECTION 1 of the bill (page 1, lines 5-16) and renumber SECTIONS of the bill appropriately.

(2) In existing SECTION 3 of the bill, in amended Section 3A, Article 3.70-3C, Insurance Code, insert a new Subsection (i) to read as follows (page 7, between lines 1 and 2) and reletter subsections and cross-references in the bill appropriately:

(i) The investigation and determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Subsection (e) or (f) of this section or for auditing a claim under Subsection (g) of this section.

(3) In existing SECTION 4 of the bill, strike added Section 3F, Article 3.70-3C, Insurance Code, and substitute the following (page 13, line 15, through page 15, line 15):

Sec. 3F. COORDINATION OF PAYMENT. (a) An insurer may require a physician or provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the insurer on the applicable form described by Section 3C of this article. Except as provided by this subsection, an insurer may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of payment under this section does not extend the period for determining whether a service is eligible for payment under Section 3A(e) or (f) of this article or for auditing a claim under Section 3A(g) of this article.

(c) A physician or provider who submits a claim for particular medical care or health care services to more than one health maintenance organization or insurer shall provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) On receipt of notice under Subsection (c) of this section, an insurer shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make

to the physician or provider.

(e) Except as provided by Subsection (f) of this section, if an insurer is a secondary payor and pays a portion of a claim that should have been paid by the insurer or health maintenance organization that is the primary payor, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary insurer was also paid by the primary health maintenance organization or insurer, the secondary insurer may recover the amount of overpayment under Section 3D of this article from the physician or provider who received the payment. An insurer processing an electronic claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. Primary payor information may be submitted electronically by the primary payor to the secondary payor.

(g) An insurer may share information with a health maintenance organization or another insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

(h) The provisions of this section may not be waived, voided, or nullified by contract.

(4) In existing SECTION 19 of the bill, strike added Section 843.349, Insurance Code (page 44, line 4, through page 46, line 6), and substitute the following:

Sec. 843.349. COORDINATION OF PAYMENT. (a) A health maintenance organization may require a physician or provider to retain in the physician's or provider's records updated information concerning other health benefit plan coverage and to provide the information to the health maintenance organization on the applicable form described by Section 843.336. Except as provided by this section, a health maintenance organization may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(b) Coordination of other payment under this section does not extend the period for determining whether a service is eligible for payment under Section 843.338 or 843.339 or for auditing a claim under Section 843.340.

(c) A participating physician or provider who submits a claim for particular health care services to more than one health maintenance organization or insurer shall provide written notice on the claim submitted to each health maintenance organization or insurer of the identity of each other health maintenance organization or insurer with which the same claim is being filed.

(d) On receipt of notice under Subsection (c), a health maintenance organization shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the physician or provider.

(e) Except as provided by Subsection (f), if a health maintenance organization is a secondary payor and pays a portion of a claim that should have been paid by the health maintenance organization or insurer that is the primary payor, the overpayment may only be recovered from the health maintenance organization or insurer that is primarily responsible for that amount.

(f) If the portion of the claim overpaid by the secondary health maintenance organization was also paid by the primary health maintenance organization or insurer, the secondary health maintenance organization may recover the amount of the overpayment under Section 843.350 from the physician or provider who received the payment. A health maintenance organization processing an electronic claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. Primary payor information may be submitted electronically by the primary payor to the secondary payor.

(g) A health maintenance organization may share information with another health maintenance organization or an insurer to the extent necessary to coordinate appropriate payment obligations on a specific claim.

(5) In existing SECTION 20 of the bill, in Section 2 of added Article 21.52Z, Insurance Code, between "ELECTRONIC SUBMISSION OF CLAIMS." and "The issuer", insert "(a)", (page 49, line 23).

(6) In existing SECTION 20 of the bill, in Section 2 of added Article 21.52Z, Insurance Code, strike "by contract shall" and substitute "by contract may" (page 49, line 24).

(7) In existing SECTION 20 of the bill, in Section 2 of added

Article 21.52Z, Insurance Code, insert a new Subsection (b) to read as follows (page 50, between lines 4 and 5):

(b) The issuer of a health benefit plan by contract shall establish a default method to submit claims in a nonelectronic format if there is a system failure or failures or a catastrophic event substantially interferes with the normal business operations of the physician, provider, or health benefit plan or its agents. The health benefit plan issuer shall comply with the standards for nonelectronic transactions established by the commissioner by rule.

(8) In existing SECTION 20 of the bill, strike Section 2A, added Article 21.52Z, Insurance Code (page 50, line 5, through page 51, line 17), and substitute the following:

Sec. 2A. ELECTRONIC SUBMISSION OF CLAIMS: WAIVER. (a) A contract between the issuer of a health benefit plan and a health care professional or health care facility must provide for a waiver of any requirement for electronic submission established under this article.

(b) The commissioner shall establish circumstances under which a waiver is required, including:

(1) circumstances in which no method is available for the submission of claims in electronic form;

(2) the operation of small physician practices;

(3) the operation of other small health care provider practices;

(4) undue hardship, including fiscal or operational hardship; or

(5) any other special circumstance that would justify a waiver.

(c) Any health care professional or health care facility that is denied a waiver by a health benefit plan may appeal the denial to the commissioner. The commissioner shall determine whether a waiver must be granted.

(d) The issuer of a health benefit plan may not refuse to contract or renew a contract with a health care professional or health care facility based in whole or in part on the professional or facility requesting or receiving a waiver or appealing a waiver

determination.

(9) Insert the following appropriately numbered SECTION:

SECTION ___. Subchapter J, Chapter 843, Insurance Code, as effective June 1, 2003, is amended by adding Section 843.3405 to read as follows:

Sec. 843.3405. INVESTIGATION AND DETERMINATION OF PAYMENT. The investigation and determination of payment, including any coordination of other payments, does not extend the period for determining whether a claim is payable under Section 843.338 or 843.339 or for auditing a claim under Section 843.340.