BILL ANALYSIS

Senate Research Center

H.B. 2256
By: Hancock et al. (Duncan)
State Affairs
5/19/2009
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities for a procedure or an emergency is ultimately responsible for an unexpected bill. Currently, there is no remedy for this bill other than the patient attempting to set up a payment plan with the facility-based physician.

H.B. 2256 relates to mediation of out-of-network health benefit claim disputes concerning enrollees, facility-based physicians, and certain health benefit plans and imposes an administrative penalty.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Sections 1467.003 and 1467.151, Insurance Code) and SECTION 2 (Sections 1301.0055 and 1301.0056, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the Texas Medical Board in SECTION 1 (Sections 1467.003 and 1467.151, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the chief administrative law judge of the State Office of Administrative Hearings in SECTION 1 (Section 1467.003, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle F, Title 8, Insurance Code, by adding Chapter 1467, as follows:

CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1467.001. DEFINITIONS. Defines "administrator," "chief administrative law judge," "enrollee," "facility-based physician," "mediation," "mediator," and "party" in this chapter.

Sec. 1467.002. APPLICABILITY OF CHAPTER. Provides that this chapter applies to a preferred provider benefit plan offered by an insurer under Chapter 1301 (Preferred Provider Benefit Plans) and an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551 (Texas Employees Group Benefits Act).

Sec. 1467.003. RULES. Requires the commissioner of insurance (commissioner), the Texas Medical Board (TMB), and the chief administrative law judge of the State Office of Administrative Hearings (SOAH) to adopt rules as necessary to implement their respective powers and duties under this chapter.

Sec. 1467.004. REMEDIES NOT EXCLUSIVE. Provides that 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. Prohibits this chapter from being construed to prohibit an insurer offering a preferred provider benefit plan or administrator from, at any time, offering a reformed claim settlement or a facility-based physician from, at any time, offering a reformed charge for medical services.

[Reserves Sections 1467.006-1467.050 for expansion.]

SUBCHAPTER B. MANDATORY MEDIATION

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION; EXCEPTION. (a) Authorizes an enrollee to request mediation of a settlement of an out-of-network health benefit claim if 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 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) Requires the facility-based physician and the insurer or the administrator, as appropriate, except as provided by Subsections (c) and (d), if an enrollee requests mediation under this subchapter, to participate in the mediation.

(c) Requires a facility-based physician, except in the case of an emergency, before providing a medical service or supply, to provide a complete disclosure to an enrollee that explains that the facility-based physician does not have a contract with the enrollee's health benefit plan, discloses specific amounts for which the enrollee may be responsible, and discloses the circumstances under which the enrollee would be responsible for those amounts.

(d) Prohibits a facility-based physician who makes a disclosure under Subsection (c) and obtains the enrollee's written acknowledgment of that disclosure from being required to mediate a billed charge under this subchapter if the amount billed is less than or equal to the maximum amount stated in the disclosure.

Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Requires a person, except as provided by Subsection (b), to qualify for an appointment as a mediator under this chapter, to 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) Authorizes a person not qualified under Subsection (a) to be appointed as a mediator on agreement of the parties.

(c) Prohibits a person from acting 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) Requires that a mediation be conducted by one mediator.

(b) Requires the chief administrative law judge to appoint the mediator through a random assignment from a list of qualified mediators maintained by SOAH.

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

(d) Requires that the mediator's fees 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) Authorizes an enrollee to request mandatory mediation under this chapter.

(b) Requires that a request for mandatory mediation be provided to the Texas Department of Insurance (TDI) on a form prescribed by the commissioner and include certain information.

(c) Requires TDI, on receipt of a request for mediation, to notify the facility-based physician and insurer or administrator of the request.

(d) Requires all parties, in an effort to settle the claim before mediation, to 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) Requires that a dispute to be mediated under this chapter that does not settle as a result of a teleconference conducted under Subsection (d) be conducted in the county in which the medical services were rendered.

(f) Authorizes the enrollee to elect to participate in the mediation. Prohibits a mediation from proceeding without the consent of the enrollee. Authorizes an enrollee to withdraw the request for mediation at any time before the mediation.

(g) Authorizes mediation, notwithstanding Subsection (f), to 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) Prohibits a mediator, except as provided by Sections 1467.056 and 1467.057, from imposing the mediator's judgment on a party about an issue that is a subject of the mediation.

(b) Provides that a mediation session is under the control of the mediator.

(c) Requires the mediator, except as provided by this chapter, to hold in strict confidence all information provided to the mediator by a party and all communications of the mediator with a party.

(d) Requires the mediator, if the enrollee is participating in the mediation in person, at the beginning of the mediation, to inform the enrollee that if the enrollee is not satisfied with the mediated agreement, the enrollee is authorized to file a complaint with TMB against the facility-based physician for improper billing and TDI for unfair claim settlement practices.

(e) Requires that a party have an opportunity during the mediation to speak and state the party's position.

(f) Prohibits a mediation, except on the agreement of the participating parties, from lasting more than four hours.

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

(h) Prohibits the facility-based physician, on receipt of notice from TDI that an enrollee has made a request for mediation that meets the requirements of this chapter, from pursuing any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and

coinsurance before the earlier of the date the mediation is completed or the date the request to mediate is withdrawn.

(i) Prohibits a service provided by a facility-based physician from being summarily disallowed. Provides that this subsection does not require an insurer or administrator to pay for an uncovered service.

(j) Prohibits a mediator from testifying 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) Requires that the parties, in a mediation under this chapter, evaluate whether the amount charged by the facility-based physician for the medical service or supply is excessive, 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 the amount for which an enrollee will be responsible to the facility-based physician, after copayments, deductibles, and coinsurance, is excessive.

(b) Authorizes the facility-based physician to present information to justify the amount charged for the medical service or supply. Authorizes the insurer or administrator to present information to justify the amount paid by the insurer.

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

(d) Provides that the goal of the mediation is to obtain agreement between the facility-based physician and the insurer or administrator, as appropriate, as to the amount to be charged by the physician and paid by the insurer or administrator to the facility-based physician.

Sec. 1467.057. NO AGREED RESOLUTION. (a) Requires the mediator of an unsuccessful mediation under this chapter to report the outcome of the mediation to TDI, TMB, and the chief administrative law judge.

(b) Requires the chief administrative law judge to enter an order of referral of a matter reported under Subsection (a) to a special judge under Chapter 151 (Trial by Special Judge), Civil Practice and Remedies Code, that names the special judge on whom the parties agreed or appoints the special judge if the parties did not agree on a judge, states the issues to be referred and the time and place on which the parties agree for the trial, requires each party to pay the party's proportionate share of the special judge's fee, and certifies that the parties have waived the right to trial by jury.

(c) Requires that a trial by the special judge selected or appointed as described by Subsection (b) 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) Provides that, notwithstanding any other provision of this section, Sections 151.012 (New Trial) and 151.013 (Right to Appeal), Civil Practice and Remedies Code, do not apply to a mediation under this chapter.

Sec. 1467.058. CONTINUATION OF MEDIATION. Authorizes the facility-based physician and the insurer or administrator, after a referral is made under Section 1467.057, to elect to continue the mediation to further determine their responsibilities. Provides that continuation of mediation under this section does not affect the amount of the billed charge to the enrollee.

Sec. 1467.059. MEDIATION AGREEMENT. Requires the mediator to prepare a confidential mediation agreement and order that states the total amount for which the

enrollee will be responsible to the facility-based physician, after copayments, deductibles, and coinsurance and any agreement reached by the parties under Section 1467.058.

Sec. 1467.060. REPORT OF MEDIATOR. Requires the mediator to report to the commissioner and TMB the names of the parties to the mediation and whether the parties reached an agreement or the mediator made a referral under Section 1467.057.

[Reserves Sections 1467.061-1467.100 for expansion.]

SUBCHAPTER C. BAD FAITH MEDIATION

Sec. 1467.101. BAD FAITH. (a) Sets forth certain conduct which constitutes bad faith mediation for purposes of this chapter.

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

(c) Requires a mediator to report bad faith mediation to the commissioner or TMB, as appropriate, following the conclusion of the mediation.

Sec. 1467.102. PENALTIES. (a) Provides that 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) Requires the regulatory agency that issued the license or certificate of authority, except for good cause shown, on a report of a mediator and appropriate proof of bad faith mediation, to impose an administrative penalty.

[Reserves Sections 1467.103-1467.150 for expansion.]

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) Requires the commissioner and TMB, as appropriate, to 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. Sets forth the required context of the rules adopted under this section.

(b) Requires TDI and TMB to maintain information on each complaint filed that concerns a claim or mediation subject to this chapter and related to a claim that is the basis of an enrollee complaint, including certain information.

(c) Provides that the information collected and maintained by TDI and TMB under Subsection (b)(2) (relating to a claim that is the basis of an enrollee complaint) is public information as defined by Section 552.002 (Definition of Public Information; Media Containing Public Information), Government Code, and is prohibited from including personally identifiable information or medical information.

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

SECTION 2. Amends Subchapter A, Chapter 1301, Insurance Code, by adding Sections 1301.0055 and 1301.0056, as follows:

Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. Requires the commissioner to adopt by rule network adequacy standards that are adapted to local markets in which an insurer offering a preferred provider benefit plan operates. Requires that the rules

include standards that ensure availability of, and accessibility to, a full range of health care practitioners to provide health care services to insureds.

Sec. 1301.0056. REIMBURSEMENT REPORTING. (a) Requires an insurer offering a preferred provider benefit plan to submit to TDI, as prescribed by the commissioner, information regarding:

(1) the methods used by the insurer to compute out-of-network reimbursements, such as a maximum allowable amount; and

(2) the effect of the computation described by Subdivision (1) on the out-of-pocket expenses of an insured.

(b) Requires the commissioner to establish by rule the information required under Subsection (a).

SECTION 3. Amends Section 1456.004, Insurance Code, by adding Subsection (c), to require 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 to 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 $500.

SECTION 4. Amends Chapter 1456, Insurance Code, by adding Section 1456.0045, as follows:

Sec. 1456.0045. REQUIRED DISCLOSURE: FACILITIES. Requires a health care facility to provide to each patient to be admitted to, or who is expected to receive services from, the facility a list containing the name and contact information for each facility-based physician with privileges to provide medical services at the facility. Requires that the list also inform patients that facility-based physicians are prohibited from having a contract with the health benefit plan with which the facility has a contract. Requires that the list also inform patients they may receive a bill for medical services from facility-based physicians for those amounts unpaid by the patient's health benefit plan.

SECTION 5. Makes application of this Act prospective.

SECTION 6. Requires the commissioner, TMB, and the chief administrative law judge of SOAH, as soon as practicable after the effective date of this Act, to adopt rules as necessary to implement and enforce this Act.

SECTION 7. Effective date: upon passage or September 1, 2009.