BILL ANALYSIS

C.S.H.B. 2256
By: Hancock
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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 and a health care facility enter into exclusive contracts with each other, but the facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility. 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.

C.S.H.B. 2256 establishes a mandatory out-of-network claim dispute resolution process, initiated by the enrollee of certain types of health benefit plans, involving the enrollee, the facility-based physician, and the insurer or the plan administrator, as appropriate. The bill provides for a three-step dispute resolution process that includes a teleconference, mediation, and a trial by judge. The bill requires the commissioner of insurance to adopt network adequacy standards and collect reimbursement reporting information from health benefit plans in an attempt to ensure that plan enrollees have a complete network of physicians available in contracted facilities. The bill requires the full disclosure by a health care facility of its exclusive contracts with physicians and the possibility that a patient may be billed by these physicians for services not paid by the patient's health care plan.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the commissioner of insurance, the Texas Medical Board, and the chief administrative law judge of the State Office of Administrative Hearings in SECTIONS 1 and 6 of this bill, and to the commissioner of insurance in SECTION 2 of this bill.

ANALYSIS

C.S.H.B. 2256 amends the Insurance Code to authorize an enrollee in a preferred provider benefit plan or a health benefit plan offered under the Texas Employees Group Benefits Act 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 $500, 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. The bill requires the facility-based physician and the insurer or the plan administrator, as appropriate, to participate in the mediation if an enrollee requests such mediation, with a certain exception. The bill authorizes a facility-based physician, 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. The bill establishes that a facility-based

physician who makes such a disclosure and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under these provisions if the amount billed is less than or equal to the maximum amount stated in the disclosure. The bill establishes that the remedies it provides are in addition to any other defense, remedy, or procedure provided by law, including the common law. The bill prohibits its provisions from at any time being construed to prohibit an administrator or an insurer offering a preferred provider benefit plan or a plan administer from offering a reformed claim settlement, or a facility-based physician from at any time offering a reformed charge for medical services.

C.S.H.B. 2256 sets forth provisions relating to mediator qualifications; the process of appointing a mediator and determining the mediator's fees; procedures for requesting a mandatory mediation, including preliminary procedures; the conduct of a mediation session; and confidentiality requirements for a mediator. The bill establishes the required matters to be considered in a mediation and specifies 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. The bill requires the mediator of an unsuccessful mediation to report the outcome to the Texas Department of Insurance (TDI), the Texas Medical Board, and the chief administrative law judge of the State Office of Administrative Hearings. The bill requires the chief administrative law judge to enter an order of referral of an unsuccessful mediation to a special judge and sets out the information to be included in the order. The bill requires a trial by the special judge to be conducted in accordance with provisions of the Civil Practice and Remedies Code governing alternate methods of dispute resolution, except that the special judge's verdict is not relevant or material to any other balance bill dispute and has no precedential value.

C.S.H.B. 2256 authorizes the facility-based physician and the insurer or plan administrator to elect to continue the mediation to further determine their responsibilities, after a referral to SOAH's chief administrative law judge is made, and specifies that such continuation does not affect the amount of the billed charge to the enrollee. The bill 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. The bill requires the mediator to report to the commissioner and the board the names of the parties to the mediation and whether the parties reached an agreement or the mediator made a referral to the chief administrative law judge of SOAH. The bill specifies the conduct that constitutes bad faith mediation, requires the mediator to report such conduct to the commissioner of insurance or board at the conclusion of the mediation, and establishes 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. The bill requires the regulatory agency that issued the license or certificate of authority to impose an administrative penalty on a report of a mediator and appropriate proof of bad faith mediation except for good cause shown.

C.S.H.B. 2256 requires the commissioner and the board, as appropriate, to adopt rules regulating the investigation and review of a filed complaint relating to the settlement of an out-of-network health benefit claim that is subject to these provisions and sets forth requirements for those rules. The bill requires TDI and the board to maintain certain information on each complaint filed and on a claim that is the basis of an enrollee complaint, provides that such information is public information, and prohibits this information from including personally identifiable information or medical information.

C.S.H.B. 2256 requires the commissioner by rule to adopt network adequacy standards that are adapted to local markets in which an insurer offering a preferred provider benefit plan operates. The bill requires the rules to include standards that ensure availability of, and accessibility to, a full range of health care practitioners to provide health care services to insureds.

C.S.H.B. 2256 requires an insurer offering a preferred provider benefit plan to submit information to TDI regarding the methods used by the insurer to compute out-of-network reimbursements and the effect of that computation on the out-of-pocket expenses of an insured. The bill requires the commissioner to establish by rule the information required.

C.S.H.B. 2256 requires a facility-based physician who bills a patient covered by a preferred provider benefit plan or a health benefit plan under the Texas Employees Group Benefits Act that does not have a contract with a facility-based physician to send a billing statement to the patient with information sufficient to notify the patient of an available mandatory mediation process 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.

C.S.H.B. 2256 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. The bill requires the list also to inform patients that facility-based physicians are prohibited from having a contract with the health benefit plan with which the facility has a contract and that patients are authorized to receive a bill for medical services from facility-based physicians for those amounts unpaid by the patient's health benefit plan.

C.S.H.B. 2256 requires the commissioner of insurance, the Texas Medical Board, and the chief administrative law judge of SOAH to adopt rules as necessary to implement their respective powers and duties under the bill's provisions as soon as practicable after the bill's effective date.

C.S.H.B. 2256 defines "administrator," "chief administrative law judge," "enrollee," "facility-based physician," "mediation," "mediator," and "party."

EFFECTIVE DATE

On passage, or, if the act does not receive the necessary vote, the act takes effect September 1, 2009.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 2256 adds provisions not in the original that establish a mandatory out-of-network claim dispute resolution process, initiated by the enrollee of certain types of health benefit plans, involving the enrollee, the facility-based physician, and the insurer or the plan administrator, as appropriate, and sets out the requirements and procedures for that process.

C.S.H.B. 2256 removes provisions in the original that prohibit exclusive contracts between hospitals, health benefit plans and physicians, requires hospitals to create complete physician networks for each health benefit plan for which that they are contracted, and requires the commissioner to determine whether a health benefit plan and hospital have created an adequate network.

C.S.H.B. 2256 differs from the original regarding the adoption of network adequacy standards and the collection of reimbursement reporting information by applying those provisions to an insurer offering a preferred provider benefit plan, rather than the types of health benefit plans specified in the original.

C.S.H.B. 2256 adds a provision not in the original requiring certain facility-based physicians to send a billing statement to a patient with information sufficient to notify the patient of the available mandatory mediation process.

C.S.H.B. 2256 adds a provision not in the original requiring a health care facility to provide to each patient a list containing the name and contact information for each facility-based physician

with privileges to provide medical services at the facility, and sets forth requirements for that list.

C.S.H.B. 2256 adds a saving provision and prospective clause not in the original. The substitute differs from the original by providing for immediate effect contingent on the bill's receiving the necessary two-thirds vote in each house or a September 1, 2009, effective date, whereas the original provides for a September 1, 2009, effective date.