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H.B. No. 2256

A BILL TO BE ENTITLED

AN ACT

relating to mediation of out-of-network health benefit claim disputes concerning enrollees, facility-based physicians, and certain health benefit plans; imposing an administrative penalty.

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

SECTION 1. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1467 to read as follows:

CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1467.001. DEFINITIONS. In this chapter:

(1) "Administrator" means:

(A) an administering firm for a health benefit plan providing coverage under Chapter 1551; and

(B) if applicable, the claims administrator for the health benefit plan.

(2) "Chief administrative law judge" means the chief administrative law judge of the State Office of Administrative Hearings.

(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.

(4) "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

1 (A) to whom the facility has granted clinical
2 privileges; and
3 (B) who provides services to patients of the
4 facility under those clinical privileges.
5 (5) "Mediation" means a process in which an impartial
6 mediator facilitates and promotes agreement between the insurer
7 offering a preferred provider benefit plan or the administrator and
8 a facility-based physician to settle a health benefit claim of an
9 enrollee.
10 (6) "Mediator" means an impartial person who is
11 appointed to conduct a mediation under this chapter.
12 (7) "Party" means an insurer offering a preferred
13 provider benefit plan, an administrator, or a facility-based
14 physician who participates in a mediation conducted under this
15 chapter. The enrollee is also considered a party to the mediation.
16 Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter
17 applies to:
18 (1) a preferred provider benefit plan offered by an
19 insurer under Chapter 1301; and
20 (2) an administrator of a health benefit plan, other
21 than a health maintenance organization plan, under Chapter 1551.
22 Sec. 1467.003. RULES. The commissioner, the Texas Medical
23 Board, and the chief administrative law judge shall adopt rules as
24 necessary to implement their respective powers and duties under
25 this chapter.
26 Sec. 1467.004. REMEDIES NOT EXCLUSIVE. The remedies
27 provided by this chapter are in addition to any other defense,

1 remedy, or procedure provided by law, including the common law.
2 Sec. 1467.005. REFORM. This chapter may not be construed to
3 prohibit:
4 (1) an insurer offering a preferred provider benefit
5 plan or administrator from, at any time, offering a reformed claim
6 settlement; or
7 (2) a facility-based physician from, at any time,
8 offering a reformed charge for medical services.
9 [Sections 1467.006-1467.050 reserved for expansion]
10 SUBCHAPTER B. MANDATORY MEDIATION
11 Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION;
12 EXCEPTION. (a) An enrollee may request mediation of a settlement of
13 an out-of-network health benefit claim if:
14 (1) the amount for which the enrollee is responsible
15 to a facility-based physician, after copayments, deductibles, and
16 coinsurance, including the amount unpaid by the administrator or
17 insurer, is greater than $1,000; and
18 (2) the health benefit claim is for a medical service
19 or supply provided by a facility-based physician in a hospital that
20 is a preferred provider or that has a contract with the
21 administrator.
22 (b) Except as provided by Subsections (c) and (d), if an
23 enrollee requests mediation under this subchapter, the
24 facility-based physician and the insurer or the administrator, as
25 appropriate, shall participate in the mediation.
26 (c) Except in the case of an emergency, a facility-based
27 physician shall, before providing a medical service or supply,

1 provide a complete disclosure to an enrollee that:
2 (1) explains that the facility-based physician does
3 not have a contract with the enrollee's health benefit plan;
4 (2) discloses specific amounts for which the enrollee
5 may be responsible; and
6 (3) discloses the circumstances under which the
7 enrollee would be responsible for those amounts.
8 (d) A facility-based physician who makes a disclosure under
9 Subsection (c) and obtains the enrollee's written acknowledgment of
10 that disclosure may not be required to mediate a billed charge under
11 this subchapter if the amount billed is less than or equal to the
12 maximum amount stated in the disclosure.
13 Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Except as
14 provided by Subsection (b), to qualify for an appointment as a
15 mediator under this chapter a person must have completed at least 40
16 classroom hours of training in dispute resolution techniques in a
17 course conducted by an alternative dispute resolution organization
18 or other dispute resolution organization approved by the chief
19 administrative law judge.
20 (b) A person not qualified under Subsection (a) may be
21 appointed as a mediator on agreement of the parties.
22 (c) A person may not act as mediator for a claim settlement
23 dispute if the person has been employed by, consulted for, or
24 otherwise had a business relationship with an insurer offering the
25 preferred provider benefit plan or a physician during the three
26 years immediately preceding the request for mediation.
27 Sec. 1467.053. APPOINTMENT OF MEDIATOR; FEES. (a) A

1 mediation shall be conducted by one mediator.
2 (b) The chief administrative law judge shall appoint the
3 mediator through a random assignment from a list of qualified
4 mediators maintained by the State Office of Administrative
5 Hearings.
6 (c) Notwithstanding Subsection (b), a person other than a
7 mediator appointed by the chief administrative law judge may
8 conduct the mediation on agreement of all of the parties and notice
9 to the chief administrative law judge.
10 (d) The mediator's fees shall be split evenly and paid by
11 the insurer or administrator and the facility-based physician.
12 Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR
13 MANDATORY MEDIATION. (a) An enrollee may request mandatory
14 mediation under this chapter.
15 (b) A request for mandatory mediation must be provided to
16 the department on a form prescribed by the commissioner and must
17 include:
18 (1) the name of the enrollee requesting mediation;
19 (2) a brief description of the claim to be mediated;
20 (3) contact information, including a telephone
21 number, for the requesting enrollee and the enrollee's counsel, if
22 the enrollee retains counsel;
23 (4) the name of the facility-based physician and name
24 of the insurer or administrator; and
25 (5) any other information the commissioner may require
26 by rule.
27 (c) On receipt of a request for mediation, the department

1 shall notify the facility-based physician and insurer or
2 administrator of the request.
3 (d) In an effort to settle the claim before mediation, all
4 parties must participate in an informal settlement teleconference
5 not later than the 30th day after the date on which the enrollee
6 submits a request for mediation under this section.
7 (e) A dispute to be mediated under this chapter that does
8 not settle as a result of a teleconference conducted under
9 Subsection (d) must be conducted in the county in which the medical
10 services were rendered.
11 (f) The enrollee may elect to participate in the mediation.
12 A mediation may not proceed without the consent of the enrollee. An
13 enrollee may withdraw the request for mediation at any time before
14 the mediation.
15 (g) Notwithstanding Subsection (f), mediation may proceed
16 without the participation of the enrollee or the enrollee's
17 representative if the enrollee or representative is not present in
18 person or through teleconference.
19 Sec. 1467.055. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a)
20 Except as provided by Sections 1467.056 and 1467.057, a mediator
21 may not impose the mediator's judgment on a party about an issue
22 that is a subject of the mediation.
23 (b) A mediation session is under the control of the
24 mediator.
25 (c) Except as provided by this chapter, the mediator must
26 hold in strict confidence all information provided to the mediator
27 by a party and all communications of the mediator with a party.

1 (d) If the enrollee is participating in the mediation in
2 person, at the beginning of the mediation the mediator shall inform
3 the enrollee that if the enrollee is not satisfied with the mediated
4 agreement, the enrollee may file a complaint with:
5 (1) the Texas Medical Board against the facility-based
6 physician for improper billing; and
7 (2) the department for unfair claim settlement
8 practices.
9 (e) A party must have an opportunity during the mediation to
10 speak and state the party's position.
11 (f) Except on the agreement of the participating parties, a
12 mediation may not last more than four hours.
13 (g) Except at the request of an enrollee, a mediation shall
14 be held not later than the 180th day after the date of the request
15 for mediation.
16 (h) On receipt of notice from the department that an
17 enrollee has made a request for mediation that meets the
18 requirements of this chapter, the facility-based physician may not
19 pursue any collection effort against the enrollee who has requested
20 mediation for amounts other than copayments, deductibles, and
21 coinsurance before the earlier of:
22 (1) the date the mediation is completed; or
23 (2) the date the request to mediate is withdrawn.
24 (i) A service provided by a facility-based physician may not
25 be summarily disallowed. This subsection does not require an
26 insurer or administrator to pay for an uncovered service.
27 (j) A mediator may not testify in a proceeding, other than a

1 proceeding to enforce this chapter, related to the mediation
2 agreement.
3 Sec. 1467.056. MATTERS CONSIDERED IN MEDIATION; AGREED
4 RESOLUTION. (a) In a mediation under this chapter, the parties
5 shall evaluate whether:
6 (1) the amount charged by the facility-based physician
7 for the medical service or supply is excessive;
8 (2) the amount paid by the insurer or administrator
9 represents the usual and customary rate for the medical service or
10 supply or is unreasonably low; and
11 (3) the amount for which an enrollee will be
12 responsible to the facility-based physician, after copayments,
13 deductibles, and coinsurance, is excessive.
14 (b) The facility-based physician may present information to
15 justify the amount charged for the medical service or supply. The
16 insurer or administrator may present information to justify the
17 amount paid by the insurer.
18 (c) Nothing in this chapter prohibits mediation of more than
19 one claim between the parties during a mediation.
20 (d) The goal of the mediation is to obtain agreement between
21 the facility-based physician and the insurer or administrator, as
22 appropriate, as to the amount to be charged by the physician and
23 paid by the insurer or administrator to the facility-based
24 physician.
25 Sec. 1467.057. NO AGREED RESOLUTION. (a) The mediator of an
26 unsuccessful mediation under this chapter shall report the outcome
27 of the mediation to the department, the Texas Medical Board, and the

1 chief administrative law judge.
2 (b) The chief administrative law judge shall enter an order
3 of referral of a matter reported under Subsection (a) to a special
4 judge under Chapter 151, Civil Practice and Remedies Code, that:
5 (1) names the special judge on whom the parties agreed
6 or appoints the special judge if the parties did not agree on a
7 judge;
8 (2) states the issues to be referred and the time and
9 place on which the parties agree for the trial;
10 (3) requires each party to pay the party's
11 proportionate share of the special judge's fee; and
12 (4) certifies that the parties have waived the right
13 to trial by jury.
14 (c) A trial by the special judge selected or appointed as
15 described by Subsection (b) must proceed under Chapter 151, Civil
16 Practice and Remedies Code, except that the special judge's verdict
17 is not relevant or material to any other balance bill dispute and
18 has no precedential value.
19 (d) Notwithstanding any other provision of this section,
20 Sections 151.012 and 151.013, Civil Practice and Remedies Code, do
21 not apply to a mediation under this chapter.
22 Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral
23 is made under Section 1467.057, the facility-based physician and
24 the insurer or administrator may elect to continue the mediation to
25 further determine their responsibilities. Continuation of
26 mediation under this section does not affect the amount of the
27 billed charge to the enrollee.

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 physician, after copayments, deductibles, and coinsurance; and

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

Sec. 1467.060. REPORT OF MEDIATOR. The mediator shall report to the commissioner and the Texas Medical Board:

(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.

[Sections 1467.061-1467.100 reserved for expansion]

SUBCHAPTER C. BAD FAITH MEDIATION

Sec. 1467.101. BAD FAITH. (a) The following conduct constitutes bad faith mediation for purposes of this chapter:

(1) failing to participate in the mediation;

(2) failing to provide information the mediator believes is necessary to facilitate an agreement; or

(3) failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement.

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

(c) A mediator shall report bad faith mediation to the commissioner or the Texas Medical Board, as appropriate, following the conclusion of the mediation.

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

[Sections 1467.103-1467.150 reserved for expansion]

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The commissioner and the Texas Medical Board, 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 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

1 availability of mandatory mediation; and
2 (5) require the administrator to include a notice of the
3 claims dispute resolution process available under this chapter with
4 the explanation of benefits sent to an enrollee.
5 (b) The department and the Texas Medical Board shall
6 maintain information:
7 (1) on each complaint filed that concerns a claim or
8 mediation subject to this chapter; and
9 (2) related to a claim that is the basis of an enrollee
10 complaint, including:
11 (A) the type of services that gave rise to the
12 dispute;
13 (B) the type and specialty of the facility-based
14 physician who provided the out-of-network service;
15 (C) the county and metropolitan area in which the
16 medical service or supply was provided;
17 (D) whether the medical service or supply was for
18 emergency care; and
19 (E) any other information about the insurer or
20 administrator the commissioner or the Texas Medical Board by rule
21 may require.
22 (c) The information collected and maintained by the
23 department and the Texas Medical Board under Subsection (b)(2) is
24 public information as defined by Section 552.002, Government Code,
25 and may not include personally identifiable information or medical
26 information.
27 (d) A facility-based physician who fails to provide a

1 disclosure under Section 1467.051 is not subject to discipline by
2 the Texas Medical Board for that failure and a cause of action is
3 not created by a failure to disclose as required by Section
4 1467.051.
5 SECTION 2. Subchapter A, Chapter 1301, Insurance Code, is
6 amended by adding Sections 1301.0055 and 1301.0056 to read as
7 follows:
8 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. The
9 commissioner shall by rule adopt network adequacy standards that
10 are adapted to local markets in which an insurer offering a
11 preferred provider benefit plan operates. The rules must include
12 standards that ensure availability of, and accessibility to, a full
13 range of health care practitioners to provide health care services
14 to insureds.
15 Sec. 1301.0056. REIMBURSEMENT REPORTING. (a) An insurer
16 offering a preferred provider benefit plan must submit to the
17 department, as prescribed by the commissioner, information
18 regarding:
19 (1) the methods used by the insurer to compute
20 out-of-network reimbursements, such as a maximum allowable amount;
21 and
22 (2) the effect of the computation described by
23 Subdivision (1) on the out-of-pocket expenses of an insured.
24 (b) The commissioner shall establish by rule the
25 information required under Subsection (a).
26 SECTION 3. Section 1456.004, Insurance Code, is amended by
27 adding Subsection (c) to read as follows:

(c) 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 shall 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. Chapter 1456, Insurance Code, is amended by adding Section 1456.0045 to read as follows:

Sec. 1456.0045. REQUIRED DISCLOSURE: FACILITIES. A health care facility shall 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 list shall also inform patients that facility-based physicians may not have a contract with the health benefit plan with which the facility has a contract. The list must 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. This Act applies only to a health benefit claim filed on or after the effective date of this Act. A claim filed before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

1 SECTION 6. As soon as practicable after the effective date
2 of this Act, the commissioner of insurance, Texas Medical Board,
3 and chief administrative law judge of the State Office of
4 Administrative Hearings shall adopt rules as necessary to implement
5 and enforce this Act.

6 SECTION 7. This Act takes effect immediately if it receives
7 a vote of two-thirds of all the members elected to each house, as
8 provided by Section 39, Article III, Texas Constitution. If this
9 Act does not receive the vote necessary for immediate effect, this
10 Act takes effect September 1, 2009.