1-1 By: Hancock, et al. (Senate Sponsor - Duncan) H.B. No. 2256
1-2 (In the Senate - Received from the House May 12, 2009;
1-3 May 13, 2009, read first time and referred to Committee on State
1-4 Affairs; May 23, 2009, reported adversely, with favorable
1-5 Committee Substitute by the following vote: Yeas 8, Nays 0;
1-6 May 23, 2009, sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR H.B. No. 2256 By: Duncan

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to mediation of out-of-network health benefit claim
1-11 disputes concerning enrollees, facility-based physicians, and
1-12 certain health benefit plans; imposing an administrative penalty.
1-13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-14 SECTION 1. Subtitle F, Title 8, Insurance Code, is amended
1-15 by adding Chapter 1467 to read as follows:
1-16 CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION
1-17 SUBCHAPTER A. GENERAL PROVISIONS
1-18 Sec. 1467.001. DEFINITIONS. In this chapter:
1-19 (1) "Administrator" means:
1-20 (A) an administering firm for a health benefit
1-21 plan providing coverage under Chapter 1551; and
1-22 (B) if applicable, the claims administrator for
1-23 the health benefit plan.
1-24 (2) "Chief administrative law judge" means the chief
1-25 administrative law judge of the State Office of Administrative
1-26 Hearings.
1-27 (3) "Enrollee" means an individual who is eligible to
1-28 receive benefits through a preferred provider benefit plan or a
1-29 health benefit plan under Chapter 1551.
1-30 (4) "Facility-based physician" means a radiologist,
1-31 an anesthesiologist, a pathologist, an emergency department
1-32 physician, or a neonatologist:
1-33 (A) to whom the facility has granted clinical
1-34 privileges; and
1-35 (B) who provides services to patients of the
1-36 facility under those clinical privileges.
1-37 (5) "Mediation" means a process in which an impartial
1-38 mediator facilitates and promotes agreement between the insurer
1-39 offering a preferred provider benefit plan or the administrator and
1-40 a facility-based physician or the physician's representative to
1-41 settle a health benefit claim of an enrollee.
1-42 (6) "Mediator" means an impartial person who is
1-43 appointed to conduct a mediation under this chapter.
1-44 (7) "Party" means an insurer offering a preferred
1-45 provider benefit plan, an administrator, or a facility-based
1-46 physician or the physician's representative who participates in a
1-47 mediation conducted under this chapter. The enrollee is also
1-48 considered a party to the mediation.
1-49 Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter
1-50 applies to:
1-51 (1) a preferred provider benefit plan offered by an
1-52 insurer under Chapter 1301; and
1-53 (2) an administrator of a health benefit plan, other
1-54 than a health maintenance organization plan, under Chapter 1551.
1-55 Sec. 1467.003. RULES. The commissioner, the Texas Medical
1-56 Board, and the chief administrative law judge shall adopt rules as
1-57 necessary to implement their respective powers and duties under
1-58 this chapter.
1-59 Sec. 1467.004. REMEDIES NOT EXCLUSIVE. The remedies
1-60 provided by this chapter are in addition to any other defense,
1-61 remedy, or procedure provided by law, including the common law.
1-62 Sec. 1467.005. REFORM. This chapter may not be construed to
1-63 prohibit:

2-1 (1) an insurer offering a preferred provider benefit
2-2 plan or administrator from, at any time, offering a reformed claim
2-3 settlement; or
2-4 (2) a facility-based physician from, at any time,
2-5 offering a reformed charge for medical services.
2-6 [Sections 1467.006-1467.050 reserved for expansion]
2-7 SUBCHAPTER B. MANDATORY MEDIATION
2-8 Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION;
2-9 EXCEPTION. (a) An enrollee may request mediation of a settlement of
2-10 an out-of-network health benefit claim if:
2-11 (1) the amount for which the enrollee is responsible
2-12 to a facility-based physician, after copayments, deductibles, and
2-13 coinsurance, including the amount unpaid by the administrator or
2-14 insurer, is greater than $1,000; and
2-15 (2) the health benefit claim is for a medical service
2-16 or supply provided by a facility-based physician in a hospital that
2-17 is a preferred provider or that has a contract with the
2-18 administrator.
2-19 (b) Except as provided by Subsections (c) and (d), if an
2-20 enrollee requests mediation under this subchapter, the
2-21 facility-based physician or the physician's representative and the
2-22 insurer or the administrator, as appropriate, shall participate in
2-23 the mediation.
2-24 (c) Except in the case of an emergency and if requested by
2-25 the enrollee, a facility-based physician shall, before providing a
2-26 medical service or supply, provide a complete disclosure to an
2-27 enrollee that:
2-28 (1) explains that the facility-based physician does
2-29 not have a contract with the enrollee's health benefit plan;
2-30 (2) discloses projected amounts for which the enrollee
2-31 may be responsible; and
2-32 (3) discloses the circumstances under which the
2-33 enrollee would be responsible for those amounts.
2-34 (d) A facility-based physician who makes a disclosure under
2-35 Subsection (c) and obtains the enrollee's written acknowledgment of
2-36 that disclosure may not be required to mediate a billed charge under
2-37 this subchapter if the amount billed is less than or equal to the
2-38 maximum amount projected in the disclosure.
2-39 Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Except as
2-40 provided by Subsection (b), to qualify for an appointment as a
2-41 mediator under this chapter a person must have completed at least 40
2-42 classroom hours of training in dispute resolution techniques in a
2-43 course conducted by an alternative dispute resolution organization
2-44 or other dispute resolution organization approved by the chief
2-45 administrative law judge.
2-46 (b) A person not qualified under Subsection (a) may be
2-47 appointed as a mediator on agreement of the parties.
2-48 (c) A person may not act as mediator for a claim settlement
2-49 dispute if the person has been employed by, consulted for, or
2-50 otherwise had a business relationship with an insurer offering the
2-51 preferred provider benefit plan or a physician during the three
2-52 years immediately preceding the request for mediation.
2-53 Sec. 1467.053. APPOINTMENT OF MEDIATOR; FEES. (a) A
2-54 mediation shall be conducted by one mediator.
2-55 (b) The chief administrative law judge shall appoint the
2-56 mediator through a random assignment from a list of qualified
2-57 mediators maintained by the State Office of Administrative
2-58 Hearings.
2-59 (c) Notwithstanding Subsection (b), a person other than a
2-60 mediator appointed by the chief administrative law judge may
2-61 conduct the mediation on agreement of all of the parties and notice
2-62 to the chief administrative law judge.
2-63 (d) The mediator's fees shall be split evenly and paid by
2-64 the insurer or administrator and the facility-based physician.
2-65 Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR
2-66 MANDATORY MEDIATION. (a) An enrollee may request mandatory
2-67 mediation under this chapter.
2-68 (b) A request for mandatory mediation must be provided to
2-69 the department on a form prescribed by the commissioner and must

3-1 include:
3-2 (1) the name of the enrollee requesting mediation;
3-3 (2) a brief description of the claim to be mediated;
3-4 (3) contact information, including a telephone
3-5 number, for the requesting enrollee and the enrollee's counsel, if
3-6 the enrollee retains counsel;
3-7 (4) the name of the facility-based physician and name
3-8 of the insurer or administrator; and
3-9 (5) any other information the commissioner may require
3-10 by rule.
3-11 (c) On receipt of a request for mediation, the department
3-12 shall notify the facility-based physician and insurer or
3-13 administrator of the request.
3-14 (d) In an effort to settle the claim before mediation, all
3-15 parties must participate in an informal settlement teleconference
3-16 not later than the 30th day after the date on which the enrollee
3-17 submits a request for mediation under this section.
3-18 (e) A dispute to be mediated under this chapter that does
3-19 not settle as a result of a teleconference conducted under
3-20 Subsection (d) must be conducted in the county in which the medical
3-21 services were rendered.
3-22 (f) The enrollee may elect to participate in the mediation.
3-23 A mediation may not proceed without the consent of the enrollee. An
3-24 enrollee may withdraw the request for mediation at any time before
3-25 the mediation.
3-26 (g) Notwithstanding Subsection (f), mediation may proceed
3-27 without the participation of the enrollee or the enrollee's
3-28 representative if the enrollee or representative is not present in
3-29 person or through teleconference.
3-30 Sec. 1467.055. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a)
3-31 A mediator may not impose the mediator's judgment on a party about
3-32 an issue that is a subject of the mediation.
3-33 (b) A mediation session is under the control of the
3-34 mediator.
3-35 (c) Except as provided by this chapter, the mediator must
3-36 hold in strict confidence all information provided to the mediator
3-37 by a party and all communications of the mediator with a party.
3-38 (d) If the enrollee is participating in the mediation in
3-39 person, at the beginning of the mediation the mediator shall inform
3-40 the enrollee that if the enrollee is not satisfied with the mediated
3-41 agreement, the enrollee may file a complaint with:
3-42 (1) the Texas Medical Board against the facility-based
3-43 physician for improper billing; and
3-44 (2) the department for unfair claim settlement
3-45 practices.
3-46 (e) A party must have an opportunity during the mediation to
3-47 speak and state the party's position.
3-48 (f) Except on the agreement of the participating parties, a
3-49 mediation may not last more than four hours.
3-50 (g) Except at the request of an enrollee, a mediation shall
3-51 be held not later than the 180th day after the date of the request
3-52 for mediation.
3-53 (h) On receipt of notice from the department that an
3-54 enrollee has made a request for mediation that meets the
3-55 requirements of this chapter, the facility-based physician may not
3-56 pursue any collection effort against the enrollee who has requested
3-57 mediation for amounts other than copayments, deductibles, and
3-58 coinsurance before the earlier of:
3-59 (1) the date the mediation is completed; or
3-60 (2) the date the request to mediate is withdrawn.
3-61 (i) A service provided by a facility-based
3-62 physician may not be summarily disallowed. This subsection does
3-63 not require an insurer or administrator to pay for an uncovered
3-64 service.
3-65 (j) A mediator may not testify in a proceeding, other than a
3-66 proceeding to enforce this chapter, related to the mediation
3-67 agreement.
3-68 Sec. 1467.056. MATTERS CONSIDERED IN MEDIATION; AGREED
3-69 RESOLUTION. (a) In a mediation under this chapter, the parties

4-1 shall:
4-2 (1) evaluate whether:
4-3 (A) the amount charged by the facility-based
4-4 physician for the medical service or supply is excessive; and
4-5 (B) the amount paid by the insurer or
4-6 administrator represents the usual and customary rate for the
4-7 medical service or supply or is unreasonably low; and
4-8 (2) as a result of the amounts described by
4-9 Subdivision (1), determine the amount, after copayments,
4-10 deductibles, and coinsurance are applied, for which an enrollee is
4-11 responsible to the facility-based physician,.
4-12 (b) The facility-based physician may present information
4-13 regarding the amount charged for the medical service or supply. The
4-14 insurer or administrator may present information regarding the
4-15 amount paid by the insurer.
4-16 (c) Nothing in this chapter prohibits mediation of more than
4-17 one claim between the parties during a mediation.
4-18 (d) The goal of the mediation is to reach an agreement among
4-19 the enrollee, the facility-based physician, and the insurer or
4-20 administrator, as applicable, as to the amount paid by the insurer
4-21 or administrator to the facility-based physician, the amount
4-22 charged by the facility-based physician, and the amount paid to the
4-23 facility-based physician by the enrollee.
4-24 Sec. 1467.057. NO AGREED RESOLUTION. (a) The mediator of
4-25 an unsuccessful mediation under this chapter shall report the
4-26 outcome of the mediation to the department, the Texas Medical
4-27 Board, and the chief administrative law judge.
4-28 (b) The chief administrative law judge shall enter an order
4-29 of referral of a matter reported under Subsection (a) to a special
4-30 judge under Chapter 151, Civil Practice and Remedies Code, that:
4-31 (1) names the special judge on whom the parties agreed
4-32 or appoints the special judge if the parties did not agree on a
4-33 judge;
4-34 (2) states the issues to be referred and the time and
4-35 place on which the parties agree for the trial;
4-36 (3) requires each party to pay the party's
4-37 proportionate share of the special judge's fee; and
4-38 (4) certifies that the parties have waived the right
4-39 to trial by jury.
4-40 (c) A trial by the special judge selected or appointed as
4-41 described by Subsection (b) must proceed under Chapter 151, Civil
4-42 Practice and Remedies Code, except that the special judge's verdict
4-43 is not relevant or material to any other balance bill dispute and
4-44 has no precedential value.
4-45 (d) Notwithstanding any other provision of this section,
4-46 Sections 151.012 and 151.013, Civil Practice and Remedies Code, do
4-47 not apply to a mediation under this chapter.
4-48 Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral
4-49 is made under Section 1467.057, the facility-based physician and
4-50 the insurer or administrator may elect to continue the mediation to
4-51 further determine their responsibilities. Continuation of
4-52 mediation under this section does not affect the amount of the
4-53 billed charge to the enrollee.
4-54 Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall
4-55 prepare a confidential mediation agreement and order that states:
4-56 (1) the total amount for which the enrollee will be
4-57 responsible to the facility-based physician, after copayments,
4-58 deductibles, and coinsurance; and
4-59 (2) any agreement reached by the parties under Section
4-60 1467.058.
4-61 Sec. 1467.060. REPORT OF MEDIATOR. The mediator shall
4-62 report to the commissioner and the Texas Medical Board:
4-63 (1) the names of the parties to the mediation; and
4-64 (2) whether the parties reached an agreement or the
4-65 mediator made a referral under Section 1467.057.
4-66 [Sections 1467.061-1467.100 reserved for expansion]
4-67 SUBCHAPTER C. BAD FAITH MEDIATION
4-68 Sec. 1467.101. BAD FAITH. (a) The following conduct
4-69 constitutes bad faith mediation for purposes of this chapter:

5-1 (1) failing to participate in the mediation;
5-2 (2) failing to provide information the mediator
5-3 believes is necessary to facilitate an agreement; or
5-4 (3) failing to designate a representative
5-5 participating in the mediation with full authority to enter into
5-6 any mediated agreement.
5-7 (b) Failure to reach an agreement is not conclusive proof of
5-8 bad faith mediation.
5-9 (c) A mediator shall report bad faith mediation to the
5-10 commissioner or the Texas Medical Board, as appropriate, following
5-11 the conclusion of the mediation.
5-12 Sec. 1467.102. PENALTIES. (a) Bad faith mediation, by a
5-13 party other than the enrollee, is grounds for imposition of an
5-14 administrative penalty by the regulatory agency that issued a
5-15 license or certificate of authority to the party who committed the
5-16 violation.
5-17 (b) Except for good cause shown, on a report of a mediator
5-18 and appropriate proof of bad faith mediation, the regulatory agency
5-19 that issued the license or certificate of authority shall impose an
5-20 administrative penalty.
5-21 [Sections 1467.103-1467.150 reserved for expansion]
5-22 SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION
5-23 Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The
5-24 commissioner and the Texas Medical Board, as appropriate, shall
5-25 adopt rules regulating the investigation and review of a complaint
5-26 filed that relates to the settlement of an out-of-network health
5-27 benefit claim that is subject to this chapter. The rules adopted
5-28 under this section must:
5-29 (1) distinguish among complaints for out-of-network
5-30 coverage or payment and give priority to investigating allegations
5-31 of delayed medical care;
5-32 (2) develop a form for filing a complaint and
5-33 establish an outreach effort to inform enrollees of the
5-34 availability of the claims dispute resolution process under this
5-35 chapter;
5-36 (3) ensure that a complaint is not dismissed without
5-37 appropriate consideration;
5-38 (4) ensure that enrollees are informed of the
5-39 availability of mandatory mediation; and
5-40 (5) require the administrator to include a notice of
5-41 the claims dispute resolution process available under this chapter
5-42 with the explanation of benefits sent to an enrollee.
5-43 (b) The department and the Texas Medical Board shall
5-44 maintain information:
5-45 (1) on each complaint filed that concerns a claim or
5-46 mediation subject to this chapter; and
5-47 (2) related to a claim that is the basis of an enrollee
5-48 complaint, including:
5-49 (A) the type of services that gave rise to the
5-50 dispute;
5-51 (B) the type and specialty of the facility-based
5-52 physician who provided the out-of-network service;
5-53 (C) the county and metropolitan area in which the
5-54 medical service or supply was provided;
5-55 (D) whether the medical service or supply was for
5-56 emergency care; and
5-57 (E) any other information about:
5-58 (i) the insurer or administrator that the
5-59 commissioner by rule requires; or
5-60 (ii) the physician that the Texas Medical
5-61 Board by rule requires.
5-62 (c) The information collected and maintained by the
5-63 department and the Texas Medical Board under Subsection (b)(2) is
5-64 public information as defined by Section 552.002, Government Code,
5-65 and may not include personally identifiable information or medical
5-66 information.
5-67 (d) A facility-based physician who fails to provide a
5-68 disclosure under Section 1467.051 is not subject to discipline by
5-69 the Texas Medical Board for that failure and a cause of action is

6-1 not created by a failure to disclose as required by Section
6-2 1467.051.
6-3 SECTION 2. Subchapter A, Chapter 1301, Insurance Code, is
6-4 amended by adding Section 1301.0055 to read as follows:
6-5 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. The
6-6 commissioner shall by rule adopt network adequacy standards that:
6-7 (1) are adapted to local markets in which an insurer
6-8 offering a preferred provider benefit plan operates;
6-9 (2) ensure availability of, and accessibility to, a
6-10 full range of health care practitioners to provide health care
6-11 services to insureds; and
6-12 (3) consider situations in which no provider in a
6-13 field of practice in a local market agree to contract with a plan at
6-14 a reasonable rate of reimbursement.
6-15 SECTION 3. Section 1456.004, Insurance Code, is amended by
6-16 adding Subsection (c) to read as follows:
6-17 (c) A facility-based physician who bills a patient covered
6-18 by a preferred provider benefit plan or a health benefit plan under
6-19 Chapter 1551 that does not have a contract with the facility-based
6-20 physician shall send a billing statement to the patient with
6-21 information sufficient to notify the patient of the mandatory
6-22 mediation process available under Chapter 1467 if the amount for
6-23 which the enrollee is responsible, after copayments, deductibles,
6-24 and coinsurance, including the amount unpaid by the administrator
6-25 or insurer, is greater than $1,000.
6-26 SECTION 4. Section 324.001, Health and Safety Code, is
6-27 amended by adding subsection (8) to read as follows:
6-28 (8) "Facility-based physician" means a radiologist,
6-29 an anesthesiologist, a pathologist, an emergency department
6-30 physician, or a neonatologist.
6-31 SECTION 5. Section 324.101(a), Health and Safety Code, is
6-32 amended to read as follows:
6-33 (a) Each facility shall develop, implement, and enforce
6-34 written policies for the billing of facility health care services
6-35 and supplies. The policies must address:
6-36 (1) any discounting of facility charges to an
6-37 uninsured consumer, subject to Chapter 552, Insurance Code;
6-38 (2) any discounting of facility charges provided to a
6-39 financially or medically indigent consumer who qualifies for
6-40 indigent services based on a sliding fee scale or a written charity
6-41 care policy established by the facility and the documented income
6-42 and other resources of the consumer;
6-43 (3) the providing of an itemized statement required by
6-44 Subsection (e);
6-45 (4) whether interest will be applied to any billed
6-46 service not covered by a third-party payor and the rate of any
6-47 interest charged;
6-48 (5) the procedure for handling complaints; [~~and~~]
6-49 (6) the providing of a conspicuous written disclosure
6-50 to a consumer at the time the consumer is first admitted to the
6-51 facility or first receives services at the facility that:
6-52 (A) provides confirmation whether the facility
6-53 is a participating provider under the consumer's third-party payor
6-54 coverage on the date services are to be rendered based on the
6-55 information received from the consumer at the time the confirmation
6-56 is provided; [~~and~~]
6-57 (B) informs consumers [~~the consumer~~] that a
6-58 facility-based physician [~~or other health care provider~~] who may
6-59 provide services to the consumer while the consumer is in the
6-60 facility may not be a participating provider with the same
6-61 third-party payors as the facility;
6-62 (C) informs consumers that the consumer may
6-63 receive a bill for medical services from a facility-based physician
6-64 for the amount unpaid by the consumer's health benefit plan;
6-65 (D) informs consumers that the consumer may
6-66 request a listing of facility-based physicians who have been
6-67 granted medical staff privileges to provide medical services at
6-68 the facility; and
6-69 (E) informs consumers that the consumer may

7-1 request information from a facility-based physician on whether the
7-2 physician has a contract with the consumer's health benefit plan
7-3 and under what circumstances the consumer may be responsible for
7-4 payment of any amounts not paid by the consumer's health benefit
7-5 plan;
7-6 (7) the requirement that a facility provide a list, on
7-7 request, to a consumer to be admitted to, or who is expected to
7-8 receive services from, the facility, that contains the name and
7-9 contact information for each facility-based physician who has been
7-10 granted medical staff privileges to provide medical services at the
7-11 facility; and
7-12 (8) if the facility operates a website that includes a
7-13 listing of physicians who have been granted medical staff
7-14 privileges to provide medical services at the facility, the posting
7-15 on the facility's website of a list that contains the name and
7-16 contact information for each facility-based physician who has been
7-17 granted medical staff privileges to provide medical services at the
7-18 facility and the updating of the list in any calendar quarter in
7-19 which there are any changes to the list.
7-20 SECTION 6. This Act applies only to a health benefit claim
7-21 filed on or after the effective date of this Act. A claim filed
7-22 before the effective date of this Act is governed by the law as it
7-23 existed immediately before the effective date of this Act, and that
7-24 law is continued in effect for that purpose.
7-25 SECTION 7. As soon as practicable after the effective date
7-26 of this Act, the commissioner of insurance, Texas Medical Board,
7-27 and chief administrative law judge of the State Office of
7-28 Administrative Hearings shall adopt rules as necessary to implement
7-29 and enforce this Act.
7-30 SECTION 8. This Act takes effect immediately if it receives
7-31 a vote of two-thirds of all the members elected to each house, as
7-32 provided by Section 39, Article III, Texas Constitution. If this
7-33 Act does not receive the vote necessary for immediate effect, this
7-34 Act takes effect September 1, 2009.

7-35 * * * * *