By: Smith of Tarrant H.B. No. 2431

A BILL TO BE ENTITLED

AN ACT

relating to mediation of out-of-network health benefit claim disputes between enrollees and health benefit plan issuers.

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 SETTLEMENT MEDIATION

Sec. 1467.001. DEFINITIONS. In this chapter:

(1) "Billing code" means the American Medical Association's Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS), a revenue code, or any other code used by physicians or health care providers to obtain reimbursement.

(2) "Enrollee" means an individual who is eligible to receive benefits through a health benefit plan.

(3) "Fee array" means a schedule of the billing codes relevant to a claim settlement dispute that are used by a health benefit plan issuer in paying the claim. For each billing code, the fee array is composed of:

(A) the highest fee paid by the health benefit plan issuer for a particular medical service, health care service, or medical supply for the code during the preceding 12 calendar months;

(B) the lowest fee paid by the health benefit

plan issuer for the particular medical service, health care service, or medical supply for the code during the preceding 12 calendar months; and

(C) the median fee paid by the health benefit plan issuer for the particular medical service, health care service, or medical supply for the code during the preceding 12 calendar months.

(4) "Mediation" means a process in which an impartial mediator facilitates and promotes a voluntary agreement between the parties to settle a health benefit claim.

(5) "Mediator" means an impartial person who is appointed to conduct a mediation under this chapter.

(6) "Party" means a health benefit plan issuer or an enrollee who participates in a mediation conducted under this chapter.

Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter applies to any health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843;

(F) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Sec. 1467.003. AVAILABILITY OF MEDIATION; PUBLIC INSURANCE COUNSEL. (a) An enrollee may request mediation of a settlement of an out-of-network health benefit claim if:

(1) the health benefit plan issuer does not determine the financial responsibility of the issuer and enrollee based solely on the amount submitted on the claim by an out-of-network health care provider; and

(2) the amount for which the enrollee is responsible, including the amount unpaid by the issuer, is greater than $500.

(b) The public insurance counsel may request mediation on behalf of an enrollee under this chapter.

Sec. 1467.004. MEDIATOR QUALIFICATIONS. (a) Except as provided by Subsection (b), to qualify for an appointment as a mediator under this chapter a person must 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 commissioner.

(b) A person not qualified under Subsection (a) may be appointed as a mediator on agreement of the parties.

(c) A person may not mediate a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with, the health benefit plan issuer during the seven years immediately preceding the request for mediation.

Sec. 1467.005. APPOINTMENT OF MEDIATOR; FEES. (a) A mediation shall be conducted by one mediator.

(b) The mediator shall be appointed by the commissioner through a random assignment from a list of qualified mediators maintained by the department.

(c) Notwithstanding Subsection (b), a person other than a mediator appointed by the commissioner may conduct the mediation on agreement of the parties and notice to the commissioner.

(d) The health benefit plan issuer shall pay all costs of the mediation, including the mediator's fees.

Sec. 1467.006. REQUEST AND PRELIMINARY PROCEDURES FOR MANDATORY MEDIATION. (a) An enrollee may request mandatory mediation under this chapter.

(b) A request for mandatory mediation must be provided on a

form prescribed by the commissioner, and must include:

(1) the name of the enrollee requesting mediation;

(2) a brief description of the claim to be mediated;

(3) contact information, including a telephone number, for the requesting enrollee and the enrollee's counsel, if the enrollee retains counsel;

(4) whether the public insurance counsel will participate in the mediation; and

(5) any other information the commissioner may require by rule.

(c) Except on agreement of the parties, a mandatory mediation must take place within 30 miles of the enrollee's residence.

(d) Not later than the 60th day after the date of the appointment of a mediator, the health benefit plan issuer, for use by the parties in the mediation, shall file with the mediator the fee array for the billing codes or diagnosis-related groups related to the disputed claim settlement, together with all bundling logic and claims processing policies for the codes. The mediator shall provide a copy of the fee array to the enrollee and, if the office of public insurance counsel is involved, to the public insurance counsel, not later than the 30th day before the date on which the mediation is scheduled to occur.

Sec. 1467.007. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a) A mediator may not impose the mediator's judgment on a party about an issue that is a subject of the mediation.

(b) A mediation session is under the control of the

mediator.

(c) Except as provided by Sections 1467.008, 1467.009, and 1467.010, the mediator must hold in strict confidence all information provided by or communication with a party.

(d) A party must have an opportunity to speak and state the party's position.

(e) Legal counsel may be present to represent and advise clients about legal rights and the implication of a suggested solution.

(f) Except on the agreement of the parties, a mediation may not last more than eight hours.

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

(h) Other than to enforce this chapter, a mediator may not be called as a witness in a proceeding related to the claim settlement.

Sec. 1467.008. MEDIATION AGREEMENT. (a) If the parties reach a tentative agreement, the mediator shall provide information to prepare a proposed mediation agreement.

(b) After the parties approve the details of the proposed agreement, the parties shall agree on a person to prepare the final document. The parties may select the mediator to prepare the final document.

(c) A party that does not reach an agreement may request another mediation session which another party may decline. The request for another session may be made in writing or orally to the

mediator and may include a request for extension of time.

(d) Notwithstanding any other law, if the parties agree that they cannot reach a final mediated agreement, the mediator shall report to the commissioner that the mediation failed to produce an agreement.

(e) If the parties reach a mediated agreement, the mediator shall send a copy of the final mediated agreement to the commissioner.

Sec. 1467.009. BAD FAITH. (a) For purposes of this chapter, bad faith negotiation is a failure to:

(1) attend the mediation;

(2) provide information that the mediator indicates to a party is necessary to facilitate an agreement; or

(3) send a designated representative to the mediation with full authority to enter into a mediated agreement.

(b) Failure to reach an agreement is not in itself proof of bad faith negotiation.

(c) The mediator may terminate a mediation immediately if a party fails to negotiate in good faith.

(d) Notwithstanding any other law, a mediator shall report bad faith negotiation by a health benefit plan issuer to the commissioner following the conclusion or termination of the mediation.

(e) On appropriate proof, the commissioner shall impose on a health benefit plan issuer that is reported under Subsection (d) the maximum administrative penalty allowed under Chapter 84.

Sec. 1467.010. CONSUMER PROTECTION; RULES. (a) The

commissioner, a designee from the department's consumer protection division, or any other person designated by the commissioner, may attend a mediation held under this chapter.

(b) The commissioner shall adopt rules regulating the investigation and review of a complaint filed with the department that relates to the settlement of an out-of-network health benefit claim. 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 consumers of the availability of the mediation process under this chapter;

(3) ensure an enrollee who files a complaint about additional out-of-network billing is informed that the enrollee can request mediation of the amount paid by the health benefit plan issuer; and

(4) ensure that a complaint is not dismissed without appropriate consideration.

(c) The department shall maintain information:

(1) on each complaint filed with the department that concerns an activity regulated by this chapter; and

(2) related to an out-of-network claim that is the basis of an enrollee complaint, including:

(A) the type of services that gave rise to the dispute;

(B) the type and specialty of the physician or

other health care provider that provided the out-of-network service;

(C) the county and metropolitan area in which the health care service was provided;

(D) whether the medical or health care service was for emergency care; and

(E) any other information about the health benefit plan issuer the commissioner by rule may require.

(d) The information collected and maintained by the department under Subsection (c)(2) is public information as defined in Section 552.002, Government Code, and may not include personal identifiable information.

(e) An enrollee's request for mediation does not prohibit the department from investigating a dispute or pursuing disciplinary actions against a health benefit plan issuer.

(f) The commissioner shall adopt other rules as necessary to implement this chapter.

Sec. 1467.011. REMEDIES NOT EXCLUSIVE. The remedies provided by this chapter are in addition to any other defense, remedy, or procedure provided by law or at common law.

Sec. 1467.012. ATTORNEY-CLIENT RELATIONSHIP NOT CREATED. In bringing or participating in a mediation under this chapter, the public insurance counsel acts in the name of the state and does not establish an attorney-client relationship with a party, including an enrollee whose claim is the basis for the request for mediation or who filed a complaint with the office of public insurance counsel.

SECTION 2. This Act applies only to a claim filed with a health benefit plan issuer 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.

SECTION 3. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.