

SENATE AMENDMENTS

2nd Printing

By: Hancock, Martinez Fischer, Rodriguez,
Smith of Tarrant, et al.

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.

1 Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall
2 prepare a confidential mediation agreement and order that states:

3 (1) the total amount for which the enrollee will be
4 responsible to the facility-based physician, after copayments,
5 deductibles, and coinsurance; and

6 (2) any agreement reached by the parties under Section
7 1467.058.

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

10 (1) the names of the parties to the mediation; and

11 (2) whether the parties reached an agreement or the
12 mediator made a referral under Section 1467.057.

13 [Sections 1467.061-1467.100 reserved for expansion]

14 SUBCHAPTER C. BAD FAITH MEDIATION

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

17 (1) failing to participate in the mediation;

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

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

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

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

1 Sec. 1467.102. PENALTIES. (a) Bad faith mediation, by a
2 party other than the enrollee, is grounds for imposition of an
3 administrative penalty by the regulatory agency that issued a
4 license or certificate of authority to the party who committed the
5 violation.

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

10 [Sections 1467.103-1467.150 reserved for expansion]

11 SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

12 Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The
13 commissioner and the Texas Medical Board, as appropriate, shall
14 adopt rules regulating the investigation and review of a complaint
15 filed that relates to the settlement of an out-of-network health
16 benefit claim that is subject to this chapter. The rules adopted
17 under this section must:

18 (1) distinguish among complaints for out-of-network
19 coverage or payment and give priority to investigating allegations
20 of delayed medical care;

21 (2) develop a form for filing a complaint and
22 establish an outreach effort to inform enrollees of the
23 availability of the claims dispute resolution process under this
24 chapter;

25 (3) ensure that a complaint is not dismissed without
26 appropriate consideration;

27 (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:

1 (c) A facility-based physician who bills a patient covered
2 by a preferred provider benefit plan or a health benefit plan under
3 Chapter 1551 that does not have a contract with the facility-based
4 physician shall send a billing statement to the patient with
5 information sufficient to notify the patient of the mandatory
6 mediation process available under Chapter 1467 if the amount for
7 which the enrollee is responsible, after copayments, deductibles,
8 and coinsurance, including the amount unpaid by the administrator
9 or insurer, is greater than \$500.

10 SECTION 4. Chapter 1456, Insurance Code, is amended by
11 adding Section 1456.0045 to read as follows:

12 Sec. 1456.0045. REQUIRED DISCLOSURE: FACILITIES. A health
13 care facility shall provide to each patient to be admitted to, or
14 who is expected to receive services from, the facility a list
15 containing the name and contact information for each facility-based
16 physician with privileges to provide medical services at the
17 facility. The list shall also inform patients that facility-based
18 physicians may not have a contract with the health benefit plan with
19 which the facility has a contract. The list must also inform
20 patients they may receive a bill for medical services from
21 facility-based physicians for those amounts unpaid by the patient's
22 health benefit plan.

23 SECTION 5. This Act applies only to a health benefit claim
24 filed on or after the effective date of this Act. A claim filed
25 before the effective date of this Act is governed by the law as it
26 existed immediately before the effective date of this Act, and that
27 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.

ADOPTED

MAY 27 2009

Atty Gen
Secretary of the Senate

By: *Robert Duncan*

H.B. No. 327

Substitute the following for H.B. No. 303

By: *Robert Duncan*

C.S. H.B. No. 303

A BILL TO BE ENTITLED

1 AN ACT

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

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

7 SECTION 1. Subtitle F, Title 8, Insurance Code, is amended
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9 CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

10 SUBCHAPTER A. GENERAL PROVISIONS

11 Sec. 1467.001. DEFINITIONS. In this chapter:

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14 plan providing coverage under Chapter 1551; and

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

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

20 (3) "Enrollee" means an individual who is eligible to
21 receive benefits through a preferred provider benefit plan or a
22 health benefit plan under Chapter 1551.

23 (4) "Facility-based physician" means a radiologist,
24 an anesthesiologist, a pathologist, an emergency department

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1 physician, or a neonatologist:

2 (A) to whom the facility has granted clinical
3 privileges; and

4 (B) who provides services to patients of the
5 facility under those clinical privileges.

6 (5) "Mediation" means a process in which an impartial
7 mediator facilitates and promotes agreement between the insurer
8 offering a preferred provider benefit plan or the administrator
9 and a facility-based physician or the physician's representative
10 to settle a health benefit claim of an enrollee.

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

13 (7) "Party" means an insurer offering a preferred
14 provider benefit plan, an administrator, or a facility-based
15 physician or the physician's representative who participates in
16 a mediation conducted under this chapter. The enrollee is also
17 considered a party to the mediation.

18 Sec. 1467.002. APPLICABILITY OF CHAPTER. This chapter
19 applies to:

20 (1) a preferred provider benefit plan offered by an
21 insurer under Chapter 1301; and

22 (2) an administrator of a health benefit plan, other
23 than a health maintenance organization plan, under Chapter 1551.

24 Sec. 1467.003. RULES. The commissioner, the Texas Medical
25 Board, and the chief administrative law judge shall adopt rules
26 as necessary to implement their respective powers and duties
27 under this chapter.

1 Sec. 1467.004. REMEDIES NOT EXCLUSIVE. The remedies
2 provided by this chapter are in addition to any other defense,
3 remedy, or procedure provided by law, including the common law.

4 Sec. 1467.005. REFORM. This chapter may not be construed
5 to prohibit:

6 (1) an insurer offering a preferred provider benefit
7 plan or administrator from, at any time, offering a reformed
8 claim settlement; or

9 (2) a facility-based physician from, at any time,
10 offering a reformed charge for medical services.

11 [Sections 1467.006-1467.050 reserved for expansion]

12 SUBCHAPTER B. MANDATORY MEDIATION

13 Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION;
14 EXCEPTION. (a) An enrollee may request mediation of a
15 settlement of an out-of-network health benefit claim if:

16 (1) the amount for which the enrollee is responsible
17 to a facility-based physician, after copayments, deductibles,
18 and coinsurance, including the amount unpaid by the
19 administrator or insurer, is greater than \$1,000; and

20 (2) the health benefit claim is for a medical service
21 or supply provided by a facility-based physician in a hospital
22 that is a preferred provider or that has a contract with the
23 administrator.

24 (b) Except as provided by Subsections (c) and (d), if an
25 enrollee requests mediation under this subchapter, the facility-
26 based physician or the physician's representative and the
27 insurer or the administrator, as appropriate, shall participate

1 in the mediation.

2 (c) Except in the case of an emergency and if requested by
3 the enrollee, a facility-based physician shall, before providing
4 a medical service or supply, provide a complete disclosure to an
5 enrollee that:

6 (1) explains that the facility-based physician does
7 not have a contract with the enrollee's health benefit plan;

8 (2) discloses projected amounts for which the
9 enrollee may be responsible; and

10 (3) discloses the circumstances under which the
11 enrollee would be responsible for those amounts.

12 (d) A facility-based physician who makes a disclosure
13 under Subsection (c) and obtains the enrollee's written
14 acknowledgment of that disclosure may not be required to mediate
15 a billed charge under this subchapter if the amount billed is
16 less than or equal to the maximum amount projected in the
17 disclosure.

18 Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Except as
19 provided by Subsection (b), to qualify for an appointment as a
20 mediator under this chapter a person must have completed at
21 least 40 classroom hours of training in dispute resolution
22 techniques in a course conducted by an alternative dispute
23 resolution organization or other dispute resolution organization
24 approved by the chief administrative law judge.

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

27 (c) A person may not act as mediator for a claim

1 settlement dispute if the person has been employed by, consulted
2 for, or otherwise had a business relationship with an insurer
3 offering the preferred provider benefit plan or a physician
4 during the three years immediately preceding the request for
5 mediation.

6 Sec. 1467.053. APPOINTMENT OF MEDIATOR; FEES. (a) A
7 mediation shall be conducted by one mediator.

8 (b) The chief administrative law judge shall appoint the
9 mediator through a random assignment from a list of qualified
10 mediators maintained by the State Office of Administrative
11 Hearings.

12 (c) Notwithstanding Subsection (b), a person other than a
13 mediator appointed by the chief administrative law judge may
14 conduct the mediation on agreement of all of the parties and
15 notice to the chief administrative law judge.

16 (d) The mediator's fees shall be split evenly and paid by
17 the insurer or administrator and the facility-based physician.

18 Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR
19 MANDATORY MEDIATION. (a) An enrollee may request mandatory
20 mediation under this chapter.

21 (b) A request for mandatory mediation must be provided to
22 the department on a form prescribed by the commissioner and must
23 include:

- 24 (1) the name of the enrollee requesting mediation;
25 (2) a brief description of the claim to be mediated;
26 (3) contact information, including a telephone
27 number, for the requesting enrollee and the enrollee's counsel,

1 if the enrollee retains counsel;

2 (4) the name of the facility-based physician and name
3 of the insurer or administrator; and

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

6 (c) On receipt of a request for mediation, the department
7 shall notify the facility-based physician and insurer or
8 administrator of the request.

9 (d) In an effort to settle the claim before mediation, all
10 parties must participate in an informal settlement
11 teleconference not later than the 30th day after the date on
12 which the enrollee submits a request for mediation under this
13 section.

14 (e) A dispute to be mediated under this chapter that does
15 not settle as a result of a teleconference conducted under
16 Subsection (d) must be conducted in the county in which the
17 medical services were rendered.

18 (f) The enrollee may elect to participate in the
19 mediation. A mediation may not proceed without the consent of
20 the enrollee. An enrollee may withdraw the request for
21 mediation at any time before the mediation.

22 (g) Notwithstanding Subsection (f), mediation may proceed
23 without the participation of the enrollee or the enrollee's
24 representative if the enrollee or representative is not present
25 in person or through teleconference.

26 Sec. 1467.055. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a)
27 A mediator may not impose the mediator's judgment on a party

1 about an issue that is a subject of the mediation.

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3 mediator.

4 (c) Except as provided by this chapter, the mediator must
5 hold in strict confidence all information provided to the
6 mediator by a party and all communications of the mediator with
7 a party.

8 (d) If the enrollee is participating in the mediation in
9 person, at the beginning of the mediation the mediator shall
10 inform the enrollee that if the enrollee is not satisfied with
11 the mediated agreement, the enrollee may file a complaint with:

12 (1) the Texas Medical Board against the facility-
13 based physician for improper billing; and

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15 practices.

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17 to speak and state the party's position.

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19 a mediation may not last more than four hours.

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21 shall be held not later than the 180th day after the date of the
22 request for mediation.

23 (h) On receipt of notice from the department that an
24 enrollee has made a request for mediation that meets the
25 requirements of this chapter, the facility-based physician may
26 not pursue any collection effort against the enrollee who has
27 requested mediation for amounts other than copayments,

1 deductibles, and coinsurance before the earlier of:

2 (1) the date the mediation is completed; or

3 (2) the date the request to mediate is withdrawn.

4 (i) A service provided by a facility-based physician may
5 not be summarily disallowed. This subsection does not require
6 an insurer or administrator to pay for an uncovered service.

7 (j) A mediator may not testify in a proceeding, other than
8 a proceeding to enforce this chapter, related to the mediation
9 agreement.

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12 shall:

13 (1) evaluate whether:

14 (A) the amount charged by the facility-based
15 physician for the medical service or supply is excessive; and

16 (B) the amount paid by the insurer or
17 administrator represents the usual and customary rate for the
18 medical service or supply or is unreasonably low; and

19 (2) as a result of the amounts described by
20 Subdivision (1), determine the amount, after copayments,
21 deductibles, and coinsurance are applied, for which an enrollee
22 is responsible to the facility-based physician, .

23 (b) The facility-based physician may present information
24 regarding the amount charged for the medical service or supply.
25 The insurer or administrator may present information regarding
26 the amount paid by the insurer.

27 (c) Nothing in this chapter prohibits mediation of more

1 than one claim between the parties during a mediation.

2 (d) The goal of the mediation is to reach an agreement
3 among the enrollee, the facility-based physician, and the
4 insurer or administrator, as applicable, as to the amount paid
5 by the insurer or administrator to the facility-based physician,
6 the amount charged by the facility-based physician, and the
7 amount paid to the facility-based physician by the enrollee.

8 Sec. 1467.057. NO AGREED RESOLUTION. (a) The mediator of
9 an unsuccessful mediation under this chapter shall report the
10 outcome of the mediation to the department, the Texas Medical
11 Board, and the chief administrative law judge.

12 (b) The chief administrative law judge shall enter an
13 order of referral of a matter reported under Subsection (a) to a
14 special judge under Chapter 151, Civil Practice and Remedies
15 Code, that:

16 (1) names the special judge on whom the parties
17 agreed or appoints the special judge if the parties did not
18 agree on a judge;

19 (2) states the issues to be referred and the time
20 and place on which the parties agree for the trial;

21 (3) requires each party to pay the party's
22 proportionate share of the special judge's fee; and

23 (4) certifies that the parties have waived the right
24 to trial by jury.

25 (c) A trial by the special judge selected or appointed as
26 described by Subsection (b) must proceed under Chapter 151,
27 Civil Practice and Remedies Code, except that the special

1 judge's verdict is not relevant or material to any other balance
2 bill dispute and has no precedential value.

3 (d) Notwithstanding any other provision of this section,
4 Sections 151.012 and 151.013, Civil Practice and Remedies Code,
5 do not apply to a mediation under this chapter.

6 Sec. 1467.058. CONTINUATION OF MEDIATION. After a
7 referral is made under Section 1467.057, the facility-based
8 physician and the insurer or administrator may elect to continue
9 the mediation to further determine their responsibilities.
10 Continuation of mediation under this section does not affect the
11 amount of the billed charge to the enrollee.

12 Sec. 1467.059. MEDIATION AGREEMENT. The mediator shall
13 prepare a confidential mediation agreement and order that
14 states:

15 (1) the total amount for which the enrollee will be
16 responsible to the facility-based physician, after copayments,
17 deductibles, and coinsurance; and

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

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

22 (1) the names of the parties to the mediation; and

23 (2) whether the parties reached an agreement or the
24 mediator made a referral under Section 1467.057.

25 [Sections 1467.061-1467.100 reserved for expansion]

26 SUBCHAPTER C. BAD FAITH MEDIATION

27 Sec. 1467.101. BAD FAITH. (a) The following conduct

1 constitutes bad faith mediation for purposes of this chapter:

2 (1) failing to participate in the mediation;

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

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

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

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

13 Sec. 1467.102. PENALTIES. (a) Bad faith mediation, by a
14 party other than the enrollee, is grounds for imposition of an
15 administrative penalty by the regulatory agency that issued a
16 license or certificate of authority to the party who committed
17 the violation.

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

22 [Sections 1467.103-1467.150 reserved for expansion]

23 SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

24 Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The
25 commissioner and the Texas Medical Board, as appropriate, shall
26 adopt rules regulating the investigation and review of a
27 complaint filed that relates to the settlement of an out-of-

1 network health benefit claim that is subject to this chapter.

2 The rules adopted under this section must:

3 (1) distinguish among complaints for out-of-network
4 coverage or payment and give priority to investigating
5 allegations of delayed medical care;

6 (2) develop a form for filing a complaint and
7 establish an outreach effort to inform enrollees of the
8 availability of the claims dispute resolution process under this
9 chapter;

10 (3) ensure that a complaint is not dismissed without
11 appropriate consideration;

12 (4) ensure that enrollees are informed of the
13 availability of mandatory mediation; and

14 (5) require the administrator to include a notice of
15 the claims dispute resolution process available under this
16 chapter with the explanation of benefits sent to an enrollee.

17 (b) The department and the Texas Medical Board shall
18 maintain information:

19 (1) on each complaint filed that concerns a claim or
20 mediation subject to this chapter; and

21 (2) related to a claim that is the basis of an
22 enrollee complaint, including:

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

25 (B) the type and specialty of the facility-based
26 physician who provided the out-of-network service;

27 (C) the county and metropolitan area in which

1 the medical service or supply was provided;

2 (D) whether the medical service or supply was
3 for emergency care; and

4 (E) any other information about:

5 (i) the insurer or administrator that the
6 commissioner by rule requires; or

7 (ii) the physician that the Texas Medical
8 Board by rule requires.

9 (c) The information collected and maintained by the
10 department and the Texas Medical Board under Subsection (b)(2)
11 is public information as defined by Section 552.002, Government
12 Code, and may not include personally identifiable information or
13 medical information.

14 (d) A facility-based physician who fails to provide a
15 disclosure under Section 1467.051 is not subject to discipline
16 by the Texas Medical Board for that failure and a cause of
17 action is not created by a failure to disclose as required by
18 Section 1467.051.

19 SECTION 2. Subchapter A, Chapter 1301, Insurance Code, is
20 amended by adding Section 1301.0055 to read as follows:

21 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. The
22 commissioner shall by rule adopt network adequacy standards
23 that:

24 (1) are adapted to local markets in which an insurer
25 offering a preferred provider benefit plan operates;

26 (2) ensure availability of, and accessibility to, a
27 full range of health care practitioners to provide health care

1 services to insureds; and

2 (3) consider situations in which no provider in a
3 field of practice in a local market agree to contract with a
4 plan at a reasonable rate of reimbursement.

5 SECTION 3. Section 1456.004, Insurance Code, is amended by
6 adding Subsection (c) to read as follows:

7 (c) A facility-based physician who bills a patient covered
8 by a preferred provider benefit plan or a health benefit plan
9 under Chapter 1551 that does not have a contract with the
10 facility-based physician shall send a billing statement to the
11 patient with information sufficient to notify the patient of the
12 mandatory mediation process available under Chapter 1467 if the
13 amount for which the enrollee is responsible, after copayments,
14 deductibles, and coinsurance, including the amount unpaid by the
15 administrator or insurer, is greater than \$1,000.

16 SECTION 4. Section 324.001, Health and Safety Code, is
17 amended by adding subsection (8) to read as follows:

18 (8) "Facility-based physician" means a radiologist,
19 an anesthesiologist, a pathologist, an emergency department
20 physician, or a neonatologist.

21 SECTION 5. Section 324.101(a), Health and Safety Code, is
22 amended to read as follows:

23 (a) Each facility shall develop, implement, and enforce
24 written policies for the billing of facility health care
25 services and supplies. The policies must address:

26 (1) any discounting of facility charges to an
27 uninsured consumer, subject to Chapter 552, Insurance Code;

1 (2) any discounting of facility charges provided to a
2 financially or medically indigent consumer who qualifies for
3 indigent services based on a sliding fee scale or a written
4 charity care policy established by the facility and the
5 documented income and other resources of the consumer;

6 (3) the providing of an itemized statement required
7 by Subsection (e);

8 (4) whether interest will be applied to any billed
9 service not covered by a third-party payor and the rate of any
10 interest charged;

11 (5) the procedure for handling complaints; [and]

12 (6) the providing of a conspicuous written disclosure
13 to a consumer at the time the consumer is first admitted to the
14 facility or first receives services at the facility that:

15 (A) provides confirmation whether the facility
16 is a participating provider under the consumer's third-party
17 payor coverage on the date services are to be rendered based on
18 the information received from the consumer at the time the
19 confirmation is provided; [and]

20 (B) informs consumers [the consumer] that a
21 facility-based physician [or other health care provider] who may
22 provide services to the consumer while the consumer is in the
23 facility may not be a participating provider with the same
24 third-party payors as the facility;

25 (C) informs consumers that the consumer may
26 receive a bill for medical services from a facility-based
27 physician for the amount unpaid by the consumer's health benefit

1 plan;

2 (D) informs consumers that the consumer may
3 request a listing of facility-based physicians who have been
4 granted medical staff privileges to provide medical services at
5 the facility; and

6 (E) informs consumers that the consumer may
7 request information from a facility-based physician on whether
8 the physician has a contract with the consumer's health benefit
9 plan and under what circumstances the consumer may be
10 responsible for payment of any amounts not paid by the
11 consumer's health benefit plan;

12 (7) the requirement that a facility provide a list, on
13 request, to a consumer to be admitted to, or who is expected to
14 receive services from, the facility, that contains the name and
15 contact information for each facility-based physician who has
16 been granted medical staff privileges to provide medical
17 services at the facility; and

18 (8) if the facility operates a website that includes a
19 listing of physicians who have been granted medical staff
20 privileges to provide medical services at the facility, the
21 posting on the facility's website of a list that contains the
22 name and contact information for each facility-based physician
23 who has been granted medical staff privileges to provide medical
24 services at the facility and the updating of the list in any
25 calendar quarter in which there are any changes to the list.

26 SECTION 6. This Act applies only to a health benefit claim
27 filed on or after the effective date of this Act. A claim filed

9.140.409 pmo

1 before the effective date of this Act is governed by the law as
2 it existed immediately before the effective date of this Act,
3 and that law is continued in effect for that purpose.

4 SECTION 7. As soon as practicable after the effective date
5 of this Act, the commissioner of insurance, Texas Medical Board,
6 and chief administrative law judge of the State Office of
7 Administrative Hearings shall adopt rules as necessary to
8 implement and enforce this Act.

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

ADOPTED

MAY 27 2009

Atay Spaw
Secretary of the Senate

FLOOR AMENDMENT NO. 1

BY: *Robert Duncan*

1 Amend H.B. No. 2256 (senate committee printing) as follows:

2 (1) In SECTION 1 of the bill, in added Section 1467.057(d),
3 Insurance Code (page 4, line 46), strike "Sections 151.012 and
4 151.013, Civil Practice and Remedies Code, do", and substitute
5 "Section 151.012, Civil Practice and Remedies Code, does".

6 (2) In SECTION 2 of the bill, in added Section 1301.0055(2),
7 Insurance Code (page 6, line 10), strike "health care
8 practitioners" and substitute "contracted physicians and health
9 care providers".

10 (3) In SECTION 2 of the bill, in added Section 1301.0055,
11 Insurance Code (page 6, lines 12-14), strike Subdivision (3) and
12 substitute the following:

13 (3) on good cause shown, may allow departure from
14 local market network adequacy standards if the commissioner posts
15 on the department's Internet website the name of the preferred
16 provider plan, the insurer offering the plan, and the affected
17 local market.

18 (4) In SECTION 5 of the bill, in added Section
19 324.101(a)(7), Health and Safety Code (page 7, line 9), strike
20 "facility-based physician who" and substitute "facility-based
21 physician or facility-based physician group that".

22 (5) In SECTION 5 of the bill, in added Section
23 324.101(a)(8), Health and Safety Code (page 7, line 16), strike
24 "facility-based physician who" and substitute "facility-based
25 physician or facility-based physician group that".

26 (6) In SECTION 6 of the bill (page 7, line 20), strike "This
27 Act applies" and substitute "(a) Except as provided by Subsection
28 (b), this Act applies".

29 (7) In SECTION 6 of the bill (page 7, between lines 24 and

1 25), insert the following:

2 (b) Section 1467.002(2), Insurance Code, as added by this
3 Act, applies to a health benefit claim filed under a group policy or
4 contract executed under Chapter 1551, Insurance Code, on or after
5 September 1, 2010. A claim filed under a group policy or contract
6 executed under Chapter 1551, Insurance Code, before September 1,
7 2010, is governed by the law as it existed immediately before
8 September 1, 2010, and that law is continued in effect for that
9 purpose.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 28, 2009

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: HB2256 by Hancock (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.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2256, As Passed 2nd House: a negative impact of (\$5,111,923) through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	\$0
2011	(\$5,111,923)
2012	(\$5,292,343)
2013	(\$5,412,624)
2014	(\$5,593,045)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>State Highway Fund</i> 6	Probable (Cost) from <i>Federal Funds</i> 555
2010	\$121,520	(\$121,520)	\$0	\$0
2011	\$86,760	(\$5,198,683)	(\$1,164,222)	(\$1,143,132)
2012	\$86,760	(\$5,379,103)	(\$1,205,312)	(\$1,183,478)
2013	\$86,760	(\$5,499,384)	(\$1,232,705)	(\$1,210,375)
2014	\$86,760	(\$5,679,805)	(\$1,273,795)	(\$1,250,721)

Fiscal Year	Probable (Cost) from <i>GR Dedicated Accounts</i> 994	Probable (Cost) from <i>Other Special State Funds</i> 998	Change in Number of State Employees from FY 2009
2010	\$0	\$0	1.5
2011	(\$211,737)	(\$22,387)	1.5
2012	(\$219,210)	(\$23,177)	1.5
2013	(\$224,192)	(\$23,704)	1.5
2014	(\$231,665)	(\$24,494)	1.5

Fiscal Analysis

The bill would amend the Insurance Code to require an out-of-network claim dispute resolution process through mediation. The bill would require the State Office of Administrative Hearings (SOAH) to appoint the mediator from a group of qualified mediators or the parties may agree to use a non-SOAH mediator and pay for the outside mediator's fees. The bill would provide that if the mediation is not successful, the case would be referred to SOAH. The bill would require the administrator of the plan and the physician to reimburse the mediator or SOAH for any expenses. The bill would allow an enrollee in a health benefit plan that participated in mediation to file a complaint with the Texas Medical Board (TMB) against the facility-based physician for improper billing or file a complaint with the Texas Department of Insurance (TDI) for unfair claim settlement.

The bill would require that information regarding the mediation to be reported to TMB and TDI and that information could be result in an administrative penalty. Additionally, the bill would require TMB and TDI to maintain a database of public information regarding these disputes. The bill amends the network adequacy standards regarding methods used to compute out-of-network reimbursements and the effect of the computation on the out-of-network expenses of an enrollee. The bill would require health care facilities to provide enrollees disclosures of physicians and billing practices. The bill would require TMB, SOAH, and TDI to adopt rules to implement the provisions of the bill.

Except for health benefit claims filed through the Employee Retirement System (ERS), the bill applies only to a health benefit claim filed on or after the effective date of the bill. For claims filed through ERS, the bill would only apply to claims filed on or after September 1, 2010. The bill would take effect immediately if it receives a two-thirds vote in both houses. If the bill does not receive the necessary vote for immediate effect, the bill would take effect September 1, 2009.

Methodology

Based on actuarial analysis provided by the ERS, the bill would result in increased administrative costs due to the mediation process and increased claim payments as a result of mediation. The costs are anticipated to be \$8,500,000 in fiscal year 2011. Additionally, the higher cost would require higher contributions from all employers and the members.

Based on the analysis provided by TMB, implementation of the bill would require 1.5 full-time-equivalent positions (FTEs) to investigate complaints regarding the disputes and support the complaint process. The 1.5 FTEs would cost \$61,881 in salaries and wages with associated benefits costs of \$17,679, and travel costs of \$7,200 for each fiscal year of 2010-2014. Additional one-time expenses in fiscal year 2010 would be \$34,760. Since the agency is required to cover its cost of operation, this analysis assumes that any costs realized by TMB from implementing the provisions of the bill would be covered with additional fee increases.

Based on the analysis provided by SOAH, implementation of the bill would result in additional costs which would be offset by revenue received from the administrator of the health plan and the physician. Any costs associated with the implementation of the bill are anticipated to be absorbed within existing resources.

Based on the analysis provided by TDI, any costs associated with the bill could be absorbed within existing agency resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 503 Texas Medical Board

LBB Staff: JOB, KJG, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 22, 2009

TO: Honorable Robert Duncan, Chair, Senate Committee on State Affairs

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: HB2256 by Hancock (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.), **Committee Report 2nd House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2256, Committee Report 2nd House, Substituted: a negative impact of (\$10,404,266) through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	(\$5,111,923)
2011	(\$5,292,343)
2012	(\$5,412,624)
2013	(\$5,593,045)
2014	(\$5,833,606)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>State Highway Fund</i> 6	Probable (Cost) from <i>Federal Funds</i> 555
2010	\$121,520	(\$5,233,443)	(\$1,164,222)	(\$1,143,132)
2011	\$86,760	(\$5,379,103)	(\$1,205,312)	(\$1,183,478)
2012	\$86,760	(\$5,499,384)	(\$1,232,705)	(\$1,210,375)
2013	\$86,760	(\$5,679,805)	(\$1,273,795)	(\$1,250,721)
2014	\$86,760	(\$5,920,366)	(\$1,328,582)	(\$1,304,515)

Fiscal Year	Probable (Cost) from <i>GR Dedicated Accounts</i> 994	Probable (Cost) from <i>Other Special State Funds</i> 998	Change in Number of State Employees from FY 2009
2010	(\$211,737)	(\$22,387)	1.5
2011	(\$219,210)	(\$23,177)	1.5
2012	(\$224,192)	(\$23,704)	1.5
2013	(\$231,665)	(\$24,494)	1.5
2014	(\$241,629)	(\$25,547)	1.5

Fiscal Analysis

The bill would amend the Insurance Code to require an out-of-network claim dispute resolution process through mediation. The bill would require the State Office of Administrative Hearings (SOAH) to appoint the mediator from a group of qualified mediators or the parties may agree to use a non-SOAH mediator and pay for the outside mediator's fees. The bill would provide that if the mediation is not successful, the case would be referred to SOAH. The bill would require the administrator of the plan and the physician to reimburse the mediator or SOAH for any expenses. The bill would allow an enrollee in a health benefit plan that participated in mediation to file a complaint with the Texas Medical Board (TMB) against the facility-based physician for improper billing or file a complaint with the Texas Department of Insurance (TDI) for unfair claim settlement.

The bill would require that information regarding the mediation to be reported to TMB and TDI and that information could be result in an administrative penalty. Additionally, the bill would require TMB and TDI to maintain a database of public information regarding these disputes. The bill amends the network adequacy standards regarding methods used to compute out-of-network reimbursements and the effect of the computation on the out-of-network expenses of an enrollee. The bill would require health care facilities to provide enrollees disclosures of physicians and billing practices. The bill would require TMB, SOAH, and TDI to adopt rules to implement the provisions of the bill.

The bill would only apply to health benefit claims filed on or after the effective date of the bill. The bill would take effect immediately if it receives a two-thirds vote in both houses. If the bill does not receive the necessary vote for immediate effect, the bill would take effect September 1, 2009.

Methodology

Based on actuarial analysis provided by the Employee Retirement System, the bill would result in increased administrative costs due to the mediation process and increased claim payments as a result of mediation. The costs are anticipated to be \$8,500,000 in fiscal year 2010 and \$8,800,000 in fiscal year 2011. Additionally, the higher cost would require higher contributions from all employers and the members.

Based on the analysis provided by TMB, implementation of the bill would require 1.5 full-time-equivalent positions (FTEs) to investigate complaints regarding the disputes and support the complaint process. The 1.5 FTEs would cost \$61,881 in salaries and wages with associated benefits costs of \$17,679, and travel costs of \$7,200 for each fiscal year of 2010-2014. Additional one-time expenses in fiscal year 2010 would be \$34,760. Since the agency is required to cover its cost of operation, this analysis assumes that any costs realized by TMB from implementing the provisions of the bill would be covered with additional fee increases.

Based on the analysis provided by SOAH, implementation of the bill would result in additional costs which would be offset by revenue received from the administrator of the health plan and the physician. Any costs associated with the implementation of the bill are anticipated to be absorbed within existing resources.

Based on the analysis provided by TDI, any costs associated with the bill could be absorbed within existing agency resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 503 Texas Medical Board

LBB Staff: JOB, KJG, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 20, 2009

TO: Honorable Robert Duncan, Chair, Senate Committee on State Affairs

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: HB2256 by Hancock (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.), **As Engrossed**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2256. As Engrossed: a negative impact of (\$5,472,764) through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	(\$2,646,172)
2011	(\$2,826,592)
2012	(\$2,946,873)
2013	(\$3,127,294)
2014	(\$3,367,855)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>State Highway Fund</i> 6	Probable (Cost) from <i>Federal Funds</i> 555
2010	\$121,520	(\$2,767,692)	(\$602,656)	(\$591,739)
2011	\$86,760	(\$2,913,352)	(\$643,746)	(\$632,085)
2012	\$86,760	(\$3,033,633)	(\$671,139)	(\$658,982)
2013	\$86,760	(\$3,214,054)	(\$712,230)	(\$699,328)
2014	\$86,760	(\$3,454,615)	(\$767,017)	(\$753,122)

Fiscal Year	Probable (Cost) from <i>GR Dedicated Accounts</i> 994	Probable (Cost) from <i>Other Special State Funds</i> 998	Change in Number of State Employees from FY 2009
2010	(\$109,605)	(\$11,588)	1.5
2011	(\$117,078)	(\$12,379)	1.5
2012	(\$122,060)	(\$12,905)	1.5
2013	(\$129,533)	(\$13,695)	1.5
2014	(\$139,497)	(\$14,749)	1.5

Fiscal Analysis

The bill would amend the Insurance Code to require an out-of-network claim dispute resolution process through mediation. The bill would require the State Office of Administrative Hearings (SOAH) to appoint the mediator from a group of qualified mediators or the parties may agree to use a non-SOAH mediator and pay for the outside mediator's fees. The bill would provide that if the mediation is not successful, the case would be referred to SOAH. The bill would require the administrator of the plan and the physician to reimburse the mediator or SOAH for any expenses. The bill would allow an enrollee in a health benefit plan that participated in mediation to file a complaint with the Texas Medical Board (TMB) against the facility-based physician for improper billing or file a complaint with the Texas Department of Insurance (TDI) for unfair claim settlement.

The bill would require that information regarding the mediation to be reported to TMB and TDI and that information could be result in an administrative penalty. Additionally, the bill would require TMB and TDI to maintain a database of public information regarding these disputes. The bill amends the network adequacy standards and reimbursement reporting regarding methods used to compute out-of-network reimbursements and the effect of the computation on the out-of-network expenses of an enrollee. The bill would require health care facilities to provide enrollees disclosures of physicians and billing practices. The bill would require TMB, SOAH, and TDI to adopt rules to implement the provisions of the bill.

The bill would only apply to health benefit claims filed on or after the effective date of the bill.

The bill would take effect immediately if it receives a two-thirds vote in both houses. If the bill does not receive the necessary vote for immediate effect, the bill would take effect September 1, 2009.

Methodology

Based on actuarial analysis provided by the Employee Retirement System, the bill would result in increased administrative costs due to the mediation process and increased claim payments as a result of mediation. The costs are anticipated to be \$4,400,000 in fiscal year 2010 and \$4,700,000 in fiscal year 2011. Additionally, the higher cost would require higher contributions from all employers and the members.

Based on the analysis provided by TMB, implementation of the bill would require 1.5 full-time-equivalent positions (FTEs) to investigate complaints regarding the disputes and support the complaint process. The 1.5 FTEs would cost \$61,881 in salaries and wages with associated benefits costs of \$17,679, and travel costs of \$7,200 for each fiscal year of 2010-2014. Additional one-time expenses in fiscal year 2010 would be \$34,760. Since the agency is required to cover its cost of operation, this analysis assumes that any costs realized by TMB from implementing the provisions of the bill would be covered with additional fee increases.

Based on the analysis provided by SOAH, implementation of the bill would result in additional costs which would be offset by revenue received from the administrator of the health plan and the physician. Any costs associated with the implementation of the bill are anticipated to be absorbed within existing resources.

Based on the analysis provided by TDI, any costs associated with the bill could be absorbed within existing agency resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 503 Texas Medical Board

LBB Staff: JOB, KJG, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION
Revision 1

April 29, 2009

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: HB2256 by Hancock (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.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2256, Committee Report 1st House, Substituted: a negative impact of (\$11,546,931) through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	(\$5,593,045)
2011	(\$5,953,886)
2012	(\$6,314,728)
2013	(\$6,735,710)
2014	(\$7,096,551)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>State Highway Fund</i> 6	Probable (Cost) from <i>Federal Funds</i> 555
2010	\$100,420	(\$5,693,465)	(\$1,273,795)	(\$1,250,721)
2011	\$80,160	(\$6,034,046)	(\$1,355,976)	(\$1,331,413)
2012	\$80,160	(\$6,394,888)	(\$1,438,156)	(\$1,412,104)
2013	\$80,160	(\$6,815,870)	(\$1,534,033)	(\$1,506,245)
2014	\$80,160	(\$7,176,711)	(\$1,616,213)	(\$1,586,936)

Fiscal Year	Probable (Cost) from <i>GR Dedicated Accounts</i> 994	Probable (Cost) from <i>Other Special State Funds</i> 998	Change in Number of State Employees from FY 2009
2010	(\$231,665)	(\$24,494)	1.5
2011	(\$246,611)	(\$26,074)	1.5
2012	(\$261,558)	(\$27,654)	1.5
2013	(\$278,995)	(\$29,498)	1.5
2014	(\$293,941)	(\$31,078)	1.5

Fiscal Analysis

The bill would amend the Insurance Code to require an out-of-network claim dispute resolution process through mediation. The bill would require the State Office of Administrative Hearings (SOAH) to appoint the mediator from a group of qualified mediators or the parties may agree to use a non-SOAH mediator and pay for the outside mediator's fees. The bill would provide that if the mediation is not successful, the case would be referred to SOAH. The bill would require the administrator of the plan and the physician to reimburse the mediator or SOAH for any expenses. The bill would allow an enrollee in a health benefit plan that participated in mediation to file a complaint with the Texas Medical Board (TMB) against the facility-based physician for improper billing or file a complaint with the Texas Department of Insurance (TDI) for unfair claim settlement. The bill would require that information regarding the mediation to be reported to TMB and TDI and that information could be result in an administrative penalty. Additionally, the bill would require TMB and TDI to maintain a database of public information regarding these disputes. The bill amends the network adequacy standards and reimbursement reporting regarding methods used to compute out-of-network reimbursements and the effect of the computation on the out-of-network expenses of an enrollee. The bill would require health care facilities to provide enrollees disclosures of physicians and billing practices. The bill would require TMB, SOAH, and TDI to adopt rules to implement the provisions of the bill.

The bill would only apply to health benefit claims filed on or after the effective date of the bill.

The bill would take effect immediately if it receives a two-thirds vote in both houses. If the bill does not receive the necessary vote for immediate effect, the bill would take effect September 1, 2009.

Methodology

Based on actuarial analysis provided by the Employee Retirement System, the bill would result in increased administrative costs due to the mediation process and increased claim payments as a result of mediation. The costs are anticipated to be \$8,373,720 in fiscal year 2010 and \$8,913,960 in fiscal year 2011. Additionally, the higher cost would require higher contributions from all employers and the members.

Based on the analysis provided by TMB, implementation of the bill would require 1.5 full-time-equivalent positions (FTEs) to investigate complaints regarding the disputes and support the complaint process. The 1.5 FTEs would cost \$61,881 in salaries and wages with associated benefits costs of \$17,679, and travel costs of \$600 for each fiscal year of 2010-2014. Additional one-time expenses in fiscal year 2010 would be \$20,260. Since the agency is required to cover its cost of operation, this analysis assumes that any costs realized by TMB from implementing the provisions of the bill would be covered with additional fee increases.

Based on the analysis provided by SOAH, implementation of the bill would result in additional costs which would be offset by revenue received from the administrator of the health plan and the physician. Any costs associated with the implementation of the bill are anticipated to be absorbed within existing resources.

Based on the analysis provided by TDI, any costs associated with the bill could be absorbed within existing agency resources.

Technology

No technology impact is anticipated.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 503 Texas Medical Board

LBB Staff: JOB, KJG, MW, CH, SD

LEGISLATIVE BUDGET BOARD

Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

April 27, 2009

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: HB2256 by Hancock (Relating to mediation of out-of-network health benefit claim disputes concerning enrollees, facility-based physicians, and certain and health benefit plans; imposing an administrative penalty.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2256, Committee Report 1st House, Substituted: a negative impact of (\$11,546,931) through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
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2012	(\$6,314,728)
2013	(\$6,735,710)
2014	(\$7,096,551)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>General Revenue Fund</i> 1	Probable (Cost) from <i>State Highway Fund</i> 6	Probable (Cost) from <i>Federal Funds</i> 555
2010	\$100,420	(\$5,693,465)	(\$1,273,795)	(\$1,250,721)
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2012	\$80,160	(\$6,394,888)	(\$1,438,156)	(\$1,412,104)
2013	\$80,160	(\$6,815,870)	(\$1,534,033)	(\$1,506,245)
2014	\$80,160	(\$7,176,711)	(\$1,616,213)	(\$1,586,936)

Fiscal Year	Probable (Cost) from <i>GR Dedicated Accounts</i> 994	Probable (Cost) from <i>Other Special State</i> <i>Funds</i> 998	Change in Number of State Employees from FY 2009
2010	(\$231,665)	(\$24,494)	1.5
2011	(\$246,611)	(\$26,074)	1.5
2012	(\$261,558)	(\$27,654)	1.5
2013	(\$278,995)	(\$29,498)	1.5
2014	(\$293,941)	(\$31,078)	1.5

Fiscal Analysis

The bill would amend the Insurance Code to require an out-of-network claim dispute resolution process through mediation. The bill would require the State Office of Administrative Hearings (SOAH) to appoint the mediator from a group of qualified mediators or the parties may agree to use a non-SOAH mediator and pay for the outside mediator's fees. The bill would provide that if the mediation is not successful, the case would be referred to SOAH. The bill would require the administrator of the plan and the physician to reimburse the mediator or SOAH for any expenses. The bill would allow an enrollee in a health benefit plan that participated in mediation to file a complaint with the Texas Medical Board (TMB) against the facility-based physician for improper billing or file a complaint with the Texas Department of Insurance (TDI) for unfair claim settlement. The bill would require that information regarding the mediation to be reported to TMB and TDI and that information could be result in an administrative penalty. Additionally, the bill would require TMB and TDI to maintain a database of public information regarding these disputes. The bill amends the network adequacy standards and reimbursement reporting regarding methods used to compute out-of-network reimbursements and the effect of the computation on the out-of-network expenses of an enrollee. The bill would require health care facilities to provide enrollees disclosures of physicians and billing practices. The bill would require TMB, SOAH, and TDI to adopt rules to implement the provisions of the bill.

The bill would only apply to health benefit claims filed on or after the effective date of the bill.

The bill would take effect immediately if it receives a two-thirds vote in both houses. If the bill does not receive the necessary vote for immediate effect, the bill would take effect September 1, 2009.

Methodology

Based on actuarial analysis provided by the Employee Retirement System, the bill would result in increased administrative costs due to the mediation process and increased claim payments as a result of mediation. The costs are anticipated to be \$8,373,720 in fiscal year 2010 and \$8,913,960 in fiscal year 2011. Additionally, the higher cost would require higher contributions from all employers and the members.

Based on the analysis provided by TMB, implementation of the bill would require 1.5 full-time-equivalent positions (FTEs) to investigate complaints regarding the disputes and support the complaint process. The 1.5 FTEs would cost \$61,881 in salaries and wages with associated benefits costs of \$17,679, and travel costs of \$600 for each fiscal year of 2010-2014. Additional one-time expenses in fiscal year 2010 would be \$20,260. Since the agency is required to cover its cost of operation, this analysis assumes that any costs realized by TMB from implementing the provisions of the bill would be covered with additional fee increases.

Based on the analysis provided by SOAH, implementation of the bill would result in additional costs which would be offset by revenue received from the administrator of the health plan and the physician. Any costs associated with the implementation of the bill are anticipated to be absorbed within existing resources.

Based on the analysis provided by TDI, any costs associated with the bill could be absorbed within existing agency resources.

Technology

No technology impact is anticipated.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 503 Texas Medical Board

LBB Staff: JOB, KJG, MW, CH

LEGISLATIVE BUDGET BOARD

Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

March 23, 2009

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: HB2256 by Hancock (Relating to requirements for contracts between physicians, hospitals, and health benefit plans.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to prohibit certain exclusive contracts or the granting of exclusive privileges between physicians, hospitals, and certain health benefit plans. It also would provide for the establishment of network adequacy standards. The bill would require a health benefit plan to submit information to the Texas Department of Insurance (TDI) about the methods used to compute out-of-network reimbursements. The bill would require TDI to adopt rules regarding the implementation of the bill. TDI indicates that it can absorb the costs associated with the bill within its current resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 323 Teacher Retirement System, 327 Employees Retirement System, 454 Department of Insurance, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: JOB, KJG, CH

