By: Schwertner S.B. No. 425

A BILL TO BE ENTITLED

AN ACT

relating to health care information provided by and notice of facility fees charged by certain freestanding emergency medical care facilities and the availability of mediation.

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

SECTION 1. Chapter 241, Health and Safety Code, is amended by adding Subchapter J to read as follows:

SUBCHAPTER J. NOTICE OF FACILITY FEES IN CERTAIN FREESTANDING EMERGENCY MEDICAL CARE FACILITIES

Sec. 241.251. APPLICABILITY. This subchapter applies only to a freestanding emergency medical care facility, as that term is defined by Section 254.001, that is exempt from the licensing requirements of Chapter 254 under Section 254.052(8).

Sec. 241.252. NOTICE OF FEES. (a) In this section, "provider network" has the meaning assigned by Section 1456.001, Insurance Code.

(b) A facility described by Section 241.251 shall post notice that states:

(1) that the facility is a freestanding emergency medical care facility and not an urgent care center;

(2) either:

(A) that the facility does not participate in a provider network; or

(B) that the facility participates in a provider

network; and

(3) any facility fee charged by the facility, including the minimum and maximum facility fee amounts charged per visit.

(c) The notice required under Subsection (b)(2)(B) must:

(1) identify the provider network;

(2) identify each physician providing medical care at the facility who is excluded from the provider network; and

(3) for each physician described by Subdivision (2), state that the physician may bill separately from the facility for the medical care provided to a patient and provide the minimum and maximum amounts the physician charges for each patient visit.

(d) The notices required by this section must be posted prominently and conspicuously:

(1) at the primary entrance to the facility;

(2) in each patient treatment room; and

(3) at each location within the facility at which a person pays for health care services.

(e) A facility that is required to post notice under this section and Section 241.183, as added by Chapter 917 (H.B. 1376), Acts of the 83rd Legislature, Regular Session, 2013, may post the required notices on the same sign.

Sec. 241.253. REQUIRED DISCLOSURE FOR CERTAIN ENROLLEES. (a) In this section:

(1) "Administrator" has the meaning assigned by Section 1467.001, Insurance Code.

(2) "Enrollee" has the meaning assigned by Section

1467.001, Insurance Code.

(b) A facility that bills an enrollee covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551, Insurance Code, shall make a disclosure to the enrollee under this section if:

(1) the facility is not a network provider for the enrollee's plan; and

(2) the facility fee amount for which the enrollee is responsible is greater than $1,000 after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer.

(c) The disclosure required under this section must be made in the billing statement provided to the enrollee and must include information sufficient to notify the patient of the mandatory mediation process available under Chapter 1467, Insurance Code.

SECTION 2. Section 254.001, Health and Safety Code, is amended by adding Subdivision (6) to read as follows:

(6) "Provider network" has the meaning assigned by Section 1456.001, Insurance Code.

SECTION 3. Subchapter D, Chapter 254, Health and Safety Code, is amended by adding Sections 254.155 and 254.156 to read as follows:

Sec. 254.155. NOTICE OF FEES. (a) A facility shall post notice that states:

(1) that the facility is a freestanding emergency medical care facility and not an urgent care center;

(2) either:

(A) that the facility does not participate in a provider network; or

(B) that the facility participates in a provider network; and

(3) any facility fee charged by the facility, including the minimum and maximum facility fee amounts charged per visit.

(b) The notice required under Subsection (a)(2)(B) must:

(1) identify the provider network;

(2) identify each physician providing medical care at the facility who is excluded from the provider network; and

(3) for each physician described by Subdivision (2), state that the physician may bill separately from the facility for the medical care provided to a patient and provide the minimum and maximum amounts the physician charges for each patient visit.

(c) The notices required by this section must be posted prominently and conspicuously:

(1) at the primary entrance to the facility;

(2) in each patient treatment room; and

(3) at each location within the facility at which a person pays for health care services.

(d) A facility that is required to post notice under this section may post the required notices on the same sign.

Sec. 254.156. REQUIRED DISCLOSURE FOR CERTAIN ENROLLEES. (a) In this section:

(1) "Administrator" has the meaning assigned by Section 1467.001, Insurance Code.

(2) "Enrollee" has the meaning assigned by Section 1467.001, Insurance Code.

(b) A facility that bills an enrollee covered by a preferred provider benefit plan or a health benefit plan under Chapter 1551, Insurance Code, shall make a disclosure to the enrollee under this section if:

(1) the facility is not a network provider for the enrollee's plan; and

(2) the facility fee amount for which the enrollee is responsible is greater than $1,000 after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer.

(c) The disclosure required under this section must be made in the billing statement provided to the enrollee and must include information sufficient to notify the patient of the mandatory mediation process available under Chapter 1467, Insurance Code.

SECTION 4. Section 324.001(7), Health and Safety Code, is amended to read as follows:

(7) "Facility" means:

(A) an ambulatory surgical center licensed under Chapter 243;

(B) a birthing center licensed under Chapter 244; [~~or~~]

(C) a hospital licensed under Chapter 241; or

(D) a freestanding emergency medical care facility, as defined in Section 254.001, including a freestanding emergency medical care facility that is exempt from the licensing

requirements of Chapter 254 under Section 254.052(8).

SECTION 5. Section 1467.001, Insurance Code, is amended by amending Subdivisions (4), (5), and (7) and adding Subdivision (4-a) to read as follows:

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

(A) to whom the facility or freestanding emergency medical care facility has granted clinical privileges; and

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

(4-a) "Freestanding emergency medical care facility" has the meaning assigned by Section 254.001, Health and Safety Code, and includes a freestanding emergency medical care facility that is exempt from the licensing requirements of Chapter 254 under Section 254.052(8).

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

(7) "Party" means an insurer offering a preferred provider benefit plan, an administrator, [~~or~~] a facility-based physician, a freestanding emergency medical care facility, or the physician's or facility's representative who participates in a

mediation conducted under this chapter. The enrollee is also considered a party to the mediation.

SECTION 6. Section 1467.003, Insurance Code, is amended to read as follows:

Sec. 1467.003. RULES. The commissioner, the Texas Medical Board, the executive commissioner of the Health and Human Services Commission for the Department of State Health Services, and the chief administrative law judge shall adopt rules as necessary to implement their respective powers and duties under this chapter.

SECTION 7. Section 1467.005, Insurance Code, is amended to read as follows:

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

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

(2) a facility-based physician or a freestanding emergency medical care facility from, at any time, offering a reformed charge for medical services or a facility fee.

SECTION 8. Section 1467.051, Insurance Code, is amended to read as follows:

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

(1) the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or

insurer, is greater than $1,000[~~,~~] and

[~~(2)~~] the health benefit claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator; or

(2) the amount for which the enrollee is responsible to a freestanding emergency medical care facility for a facility fee, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000.

(b) Except as provided by Subsections (c) and (d), if an enrollee requests mediation under this subchapter, the facility-based physician, the freestanding emergency medical care facility, or the physician's or facility's representative and the insurer or the administrator, as appropriate, shall participate in the mediation.

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

(1) explains that the facility-based physician or the freestanding emergency medical care facility does not have a contract with the enrollee's health benefit plan;

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

(3) discloses the circumstances under which the

enrollee would be responsible for those amounts.

(d) A facility-based physician or a freestanding emergency medical care facility that [~~who~~] makes a disclosure under Subsection (c) and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under this subchapter if the amount billed is less than or equal to the maximum amount projected in the disclosure.

SECTION 9. Section 1467.053(d), Insurance Code, is amended to read as follows:

(d) The mediator's fees shall be split evenly and paid by:

(1) the insurer or administrator; and

(2) the facility-based physician or freestanding emergency medical care facility, as applicable.

SECTION 10. Sections 1467.054(b) and (c), Insurance Code, are amended to read as follows:

(b) A request for mandatory mediation must be provided to the department 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) the name of the facility-based physician or freestanding emergency medical care facility and name of the insurer or administrator; and

(5) any other information the commissioner may require

by rule.

(c) On receipt of a request for mediation, the department shall notify the facility-based physician or freestanding emergency medical care facility, as applicable, and insurer or administrator of the request.

SECTION 11. Sections 1467.055(d), (h), and (i), Insurance Code, are amended to read as follows:

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

(1) the Texas Medical Board against the facility-based physician for improper billing; [~~and~~]

(2) the department for unfair claim settlement practices; and

(3) the Department of State Health Services against the freestanding emergency medical care facility for improper billing.

(h) On receipt of notice from the department that an enrollee has made a request for mediation that meets the requirements of this chapter, the facility-based physician or freestanding emergency medical care facility may not pursue any collection effort against the enrollee who has requested mediation for amounts other than copayments, deductibles, and coinsurance before the earlier of:

(1) the date the mediation is completed; or

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

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

SECTION 12. Sections 1467.056(a), (b), and (d), Insurance Code, are amended to read as follows:

(a) In a mediation under this chapter, the parties shall:

(1) evaluate whether:

(A) the amount charged by the facility-based physician or freestanding emergency medical care facility for the medical service or supply or facility fee is excessive; and

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

(2) as a result of the amounts described by Subdivision (1), determine the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is responsible to the facility-based physician or freestanding emergency medical care facility.

(b) The facility-based physician or freestanding emergency medical care facility may present information regarding the amount charged for the medical service or supply or facility fee. The insurer or administrator may present information regarding the amount paid by the insurer.

(d) The goal of the mediation is to reach an agreement among the enrollee, the facility-based physician or freestanding

emergency medical care facility, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based physician or freestanding emergency medical care facility, the amount charged by the facility-based physician or freestanding emergency medical care facility, and the amount paid to the facility-based physician or freestanding emergency medical care facility by the enrollee.

SECTION 13. Section 1467.057(a), Insurance Code, is amended to read as follows:

(a) The mediator of an unsuccessful mediation under this chapter shall report the outcome of the mediation to:

(1) the department;

(2) [,] the Texas Medical Board when the mediation involves a facility-based physician;

(3) the Department of State Health Services when the mediation involves a freestanding emergency medical care facility;[,] and

(4) the chief administrative law judge.

SECTION 14. Section 1467.058, Insurance Code, is amended to read as follows:

Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral is made under Section 1467.057, the facility-based physician or the freestanding emergency medical care facility and the insurer or administrator, as applicable, may elect to continue the mediation to further determine their responsibilities. Continuation of mediation under this section does not affect the amount of the billed charge to the enrollee.

SECTION 15. Section 1467.059, Insurance Code, is amended to read as follows:

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

(1) the total amount for which the enrollee will be responsible to the facility-based physician or freestanding emergency medical care facility, after copayments, deductibles, and coinsurance; and

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

SECTION 16. Section 1467.060, Insurance Code, is amended to read as follows:

Sec. 1467.060. REPORT OF MEDIATOR. The mediator shall report to the commissioner and, as applicable, to the Texas Medical Board when the mediation involves a facility-based physician or the Department of State Health Services when the mediation involves a freestanding emergency medical care facility:

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

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

SECTION 17. Section 1467.101(c), Insurance Code, is amended to read as follows:

(c) A mediator shall report bad faith mediation to the commissioner, [~~or~~] the Texas Medical Board, or the Department of State Health Services, as appropriate, following the conclusion of the mediation.

SECTION 18. Sections 1467.151(a), (b), and (c), Insurance

Code, are amended to read as follows:

(a) The commissioner, [~~and~~] the Texas Medical Board, and the executive commissioner of the Health and Human Services Commission for the Department of State Health Services, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. The rules adopted under this section must:

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

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

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

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

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

(b) The department, [~~and~~] the Texas Medical Board, and the Department of State Health Services shall maintain information:

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

(2) related to a claim that is the basis of an enrollee

complaint, including:

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

(B) the type and specialty of the facility-based physician who provided the out-of-network service, if any;

(C) the county and metropolitan area in which the medical service or supply was provided or facility fee was charged, as applicable;

(D) whether the medical service or supply or facility fee was for emergency care; and

(E) any other information about:

(i) the insurer or administrator that the commissioner by rule requires; [~~or~~]

(ii) the physician that the Texas Medical Board by rule requires; or

(iii) the freestanding emergency medical care facility that the executive commissioner of the Health and Human Services Commission by rule requires for the Department of State Health Services.

(c) The information collected and maintained by the department, [~~and~~] the Texas Medical Board, and the Department of State Health Services under Subsection (b)(2) is public information as defined by Section 552.002, Government Code, and may not include personally identifiable information or medical information.

SECTION 19. (a) Not later than December 1, 2015, the executive commissioner of the Health and Human Services Commission shall adopt the rules necessary to implement the changes in law made

by this Act.

(b) Notwithstanding Subchapter J, Chapter 241, Health and Safety Code, and Sections 254.155 and 254.156, Health and Safety Code, as added by this Act, a freestanding emergency medical care facility is not required to comply with those provisions until January 1, 2016.

(c) Notwithstanding Chapter 324, Health and Safety Code, as amended by this Act, a freestanding emergency medical care facility is not required to comply with Chapter 324, Health and Safety Code, until January 1, 2016.

(d) Notwithstanding Chapter 1467, Insurance Code, as amended by this Act, a mandatory mediation applies only to a facility fee that is incurred on or after January 1, 2016. A facility fee incurred before January 1, 2016, 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 20. This Act takes effect September 1, 2015.