

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 penalty.

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

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

8 CHAPTER 1467. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1467.001. DEFINITIONS. In this chapter:

11 (1) "Administrator" means:

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

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

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

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

22 (4) "Facility-based physician" means a radiologist,
23 an anesthesiologist, a pathologist, an emergency department
24 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 or the physician's representative to
9 settle a health benefit claim of an 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 or the physician's representative who participates in a
15 mediation conducted under this chapter. The enrollee is also
16 considered a party to the mediation.

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

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

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

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

27 Sec. 1467.004. REMEDIES NOT EXCLUSIVE. The remedies

1 provided by this chapter are in addition to any other defense,
2 remedy, or procedure provided by law, including the common law.

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

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

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

10 [Sections 1467.006-1467.050 reserved for expansion]

11 SUBCHAPTER B. MANDATORY MEDIATION

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

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

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

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

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

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

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

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

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

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

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

25 (c) A person may not act as mediator for a claim settlement
26 dispute if the person has been employed by, consulted for, or
27 otherwise had a business relationship with an insurer offering the

1 preferred provider benefit plan or a physician during the three
2 years immediately preceding the request for mediation.

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

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

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

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

15 Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR
16 MANDATORY MEDIATION. (a) An enrollee may request mandatory
17 mediation under this chapter.

18 (b) A request for mandatory mediation must be provided to
19 the department on a form prescribed by the commissioner and must
20 include:

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

26 (4) the name of the facility-based physician and name
27 of the insurer or administrator; and

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

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

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

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

14 (f) The enrollee may elect to participate in the mediation.
15 A mediation may not proceed without the consent of the enrollee. An
16 enrollee may withdraw the request for mediation at any time before
17 the mediation.

18 (g) Notwithstanding Subsection (f), mediation may proceed
19 without the participation of the enrollee or the enrollee's
20 representative if the enrollee or representative is not present in
21 person or through teleconference.

22 Sec. 1467.055. CONDUCT OF MEDIATION; CONFIDENTIALITY. (a)
23 A mediator may not impose the mediator's judgment on a party about
24 an issue that is a subject of the mediation.

25 (b) A mediation session is under the control of the
26 mediator.

27 (c) Except as provided by this chapter, the mediator must

1 hold in strict confidence all information provided to the mediator
2 by a party and all communications of the mediator with a party.

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

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

9 (2) the department for unfair claim settlement
10 practices.

11 (e) A party must have an opportunity during the mediation to
12 speak and state the party's position.

13 (f) Except on the agreement of the participating parties, a
14 mediation may not last more than four hours.

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

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

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

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

26 (i) A service provided by a facility-based physician may not
27 be summarily disallowed. This subsection does not require an

1 insurer or administrator to pay for an uncovered service.

2 (j) A mediator may not testify in a proceeding, other than a
3 proceeding to enforce this chapter, related to the mediation
4 agreement.

5 Sec. 1467.056. MATTERS CONSIDERED IN MEDIATION; AGREED
6 RESOLUTION. (a) In a mediation under this chapter, the parties
7 shall:

8 (1) evaluate whether:

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

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

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

18 (b) The facility-based physician may present information
19 regarding the amount charged for the medical service or supply. The
20 insurer or administrator may present information regarding the
21 amount paid by the insurer.

22 (c) Nothing in this chapter prohibits mediation of more than
23 one claim between the parties during a mediation.

24 (d) The goal of the mediation is to reach an agreement among
25 the enrollee, the facility-based physician, and the insurer or
26 administrator, as applicable, as to the amount paid by the insurer
27 or administrator to the facility-based physician, the amount

1 charged by the facility-based physician, and the amount paid to the
2 facility-based physician by the enrollee.

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

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

10 (1) names the special judge on whom the parties agreed
11 or appoints the special judge if the parties did not agree on a
12 judge;

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

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

17 (4) certifies that the parties have waived the right
18 to trial by jury.

19 (c) A trial by the special judge selected or appointed as
20 described by Subsection (b) must proceed under Chapter 151, Civil
21 Practice and Remedies Code, except that the special judge's verdict
22 is not relevant or material to any other balance bill dispute and
23 has no precedential value.

24 (d) Notwithstanding any other provision of this section,
25 Section 151.012, Civil Practice and Remedies Code, does not apply
26 to a mediation under this chapter.

27 Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral

1 is made under Section 1467.057, the facility-based physician and
2 the insurer or administrator may elect to continue the mediation to
3 further determine their responsibilities. Continuation of
4 mediation under this section does not affect the amount of the
5 billed charge to the enrollee.

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

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

11 (2) any agreement reached by the parties under Section
12 1467.058.

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

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

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

18 [Sections 1467.061-1467.100 reserved for expansion]

19 SUBCHAPTER C. BAD FAITH MEDIATION

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

22 (1) failing to participate in the mediation;

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

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

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

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

6 Sec. 1467.102. PENALTIES. (a) Bad faith mediation, by a
7 party other than the enrollee, is grounds for imposition of an
8 administrative penalty by the regulatory agency that issued a
9 license or certificate of authority to the party who committed the
10 violation.

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

15 [Sections 1467.103-1467.150 reserved for expansion]

16 SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

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

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

26 (2) develop a form for filing a complaint and
27 establish an outreach effort to inform enrollees of the

1 availability of the claims dispute resolution process under this
2 chapter;

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

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

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

10 (b) The department and the Texas Medical Board shall
11 maintain information:

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

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

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

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

20 (C) the county and metropolitan area in which the
21 medical service or supply was provided;

22 (D) whether the medical service or supply was for
23 emergency care; and

24 (E) any other information about:

25 (i) the insurer or administrator that the
26 commissioner by rule requires; or

27 (ii) the physician that the Texas Medical

1 Board by rule requires.

2 (c) The information collected and maintained by the
3 department and the Texas Medical Board under Subsection (b)(2) is
4 public information as defined by Section 552.002, Government Code,
5 and may not include personally identifiable information or medical
6 information.

7 (d) A facility-based physician who fails to provide a
8 disclosure under Section 1467.051 is not subject to discipline by
9 the Texas Medical Board for that failure and a cause of action is
10 not created by a failure to disclose as required by Section
11 1467.051.

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

14 Sec. 1301.0055. NETWORK ADEQUACY STANDARDS. The
15 commissioner shall by rule adopt network adequacy standards that:

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

18 (2) ensure availability of, and accessibility to, a
19 full range of contracted physicians and health care providers to
20 provide health care services to insureds; and

21 (3) on good cause shown, may allow departure from
22 local market network adequacy standards if the commissioner posts
23 on the department's Internet website the name of the preferred
24 provider plan, the insurer offering the plan, and the affected
25 local market.

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 \$1,000.

10 SECTION 4. Section 324.001, Health and Safety Code, is
11 amended by adding Subsection (8) to read as follows:

12 (8) "Facility-based physician" means a radiologist,
13 an anesthesiologist, a pathologist, an emergency department
14 physician, or a neonatologist.

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

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

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

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

27 (3) the providing of an itemized statement required by

1 Subsection (e);

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

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

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

9 (A) provides confirmation whether the facility
10 is a participating provider under the consumer's third-party payor
11 coverage on the date services are to be rendered based on the
12 information received from the consumer at the time the confirmation
13 is provided; ~~[and]~~

14 (B) informs consumers ~~[the consumer]~~ that a
15 facility-based physician ~~[or other health care provider]~~ who may
16 provide services to the consumer while the consumer is in the
17 facility may not be a participating provider with the same
18 third-party payors as the facility;

19 (C) informs consumers that the consumer may
20 receive a bill for medical services from a facility-based physician
21 for the amount unpaid by the consumer's health benefit plan;

22 (D) informs consumers that the consumer may
23 request a listing of facility-based physicians who have been
24 granted medical staff privileges to provide medical services at
25 the facility; and

26 (E) informs consumers that the consumer may
27 request information from a facility-based physician on whether the

1 physician has a contract with the consumer's health benefit plan
2 and under what circumstances the consumer may be responsible for
3 payment of any amounts not paid by the consumer's health benefit
4 plan;

5 (7) the requirement that a facility provide a list, on
6 request, to a consumer to be admitted to, or who is expected to
7 receive services from, the facility, that contains the name and
8 contact information for each facility-based physician or
9 facility-based physician group that has been granted medical staff
10 privileges to provide medical services at the facility; and

11 (8) if the facility operates a website that includes a
12 listing of physicians who have been granted medical staff
13 privileges to provide medical services at the facility, the posting
14 on the facility's website of a list that contains the name and
15 contact information for each facility-based physician or
16 facility-based physician group that has been granted medical staff
17 privileges to provide medical services at the facility and the
18 updating of the list in any calendar quarter in which there are any
19 changes to the list.

20 SECTION 6. (a) Except as provided by Subsection (b), this
21 Act applies only to a health benefit claim filed on or after the
22 effective date of this Act. A claim filed before the effective date
23 of this Act is governed by the law as it existed immediately before
24 the effective date of this Act, and that law is continued in effect
25 for that purpose.

26 (b) Section 1467.002(2), Insurance Code, as added by this
27 Act, applies to a health benefit claim filed under a group policy or

1 contract executed under Chapter 1551, Insurance Code, on or after
2 September 1, 2010. A claim filed under a group policy or contract
3 executed under Chapter 1551, Insurance Code, before September 1,
4 2010, is governed by the law as it existed immediately before
5 September 1, 2010, and that law is continued in effect for that
6 purpose.

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

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

David Newkum

President of the Senate

Jim Strawn

Speaker of the House

I certify that H.B. No. 2256 was passed by the House on May 11, 2009, by the following vote: Yeas 139, Nays 2, 3 present, not voting; and that the House concurred in Senate amendments to H.B. No. 2256 on May 29, 2009, by the following vote: Yeas 136, Nays 1, 4 present, not voting.

Robert Harey

Chief Clerk of the House

I certify that H.B. No. 2256 was passed by the Senate, with amendments, on May 27, 2009, by the following vote: Yeas 31, Nays 0.

Datsy Spaw

Secretary of the Senate

APPROVED: 19 JUL '09

Date

RICK PERRY

Governor

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
2 PM O'CLOCK

JUN 19 2009

Colby Hunter III