

BILL ANALYSIS

Senate Research Center
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S.B. 507
By: Hancock
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Balance billing is the practice of physicians billing a patient for the portion of medical expenses not covered by the patient's insurance. This most commonly occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities becomes ultimately responsible for an unexpected bill.

Prior to the passage of H.B. 2256, 81st Legislature, Regular Session, 2009, there was no remedy for this unexpected bill other than the patient attempting to set up a payment plan with the facility-based physician. H.B. 2256 established a new mediation process for patients who are balanced billed if the bill is more than \$1000. Despite the success of mediation, balance billing continues to be common practice, including in emergency care situations.

S.B. 481 by Senator Hancock, 84th Legislature, Regular Session, 2015, expanded options for mediation by reducing the claim threshold from \$1000 to \$500. The legislation added assistant surgeons to the list of providers subject to mediation and required patients to be notified about the option of mediation. Current law now includes facility-based radiologists, anesthesiologists, pathologists, ER physicians, neonatologists, and assistant surgeons as providers subject to mediation.

As proposed, S.B. 507 amends current law relating to mediation of the settlement of certain out-of-network health benefit claims involving balance billing.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to an appropriate regulatory agency in SECTION 3 (Section 1467.003, Insurance Code) and SECTION 16 (Section 1467.151, Insurance Code) of this bill.

Rulemaking authority previously granted to the commissioner of insurance and the Texas Medical Board is modified in SECTION 16 (Section 1467.151, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1467.001, Insurance Code, by amending Subdivisions (1), (3), (4), (5), and (7) to redefine "administrator," "enrollee," "facility-based provider," "mediation," and "party," and by adding Subdivisions (2-a), (3-a), and (4-a) to define "emergency care provider," "facility," and "health care practitioner."

SECTION 2. Amends Section 1467.002, Insurance Code, to provide that this chapter (Out-of-Network Claim Dispute Resolution) applies to an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits Program), or 1579 (Texas School Employees Uniform Group Health Coverage), rather than under Chapter 1551.

SECTION 3. Amends Section 1467.003, Insurance Code, to require the commissioner of insurance (commissioner), the Texas Medical Board (TMB), any other appropriate regulatory

agency, and the chief administrative judge, rather than the commissioner, TMB, and the chief administrative judge, to adopt necessary rules to implement their respective powers and duties.

SECTION 4. Amends Section 1467.005, Insurance Code, to prohibit this chapter from being construed to prohibit a facility-based provider or emergency care provider, rather than a facility-based physician, from, at any time, offering a reformed charge for health care or medical services, rather than for medical services.

SECTION 5. Amends Section 1467.051, Insurance code, as follows:

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

(1) makes a conforming change;

(2) the health benefit claim is for emergency care or a health care or medical service or supply provided by a facility-based provider in a facility, rather than a facility-based physician in a hospital, that meets certain criteria.

(b) to (d) Makes conforming and nonsubstantive changes.

(e) Requires a bill sent to an enrollee by a facility-based provider or emergency care provider for an out-of-network health benefit claim eligible for mediation to contain an explanation of the mediation process available. Sets forth certain requirements and required language for the statement.

SECTION 6. Amends Section 1467.052(c), Insurance Code, to prohibit a person from acting as mediator for a claim settlement dispute if the person has had certain relationships with an insurer offering the preferred provider benefit plan or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.

SECTION 7. Amends Section 1467.053(d), Insurance Code, to make a conforming change.

SECTION 8. Amends Sections 1467.054(b), (c), (d), and (e), Insurance Code, as follows:

(b) and (c) Makes conforming changes.

(d) Requires all parties, in an effort to settle the claim before mediation, to participate in an informal settlement teleconference not later than a certain date unless otherwise agreed by all parties. Provides that the facility-based provider or emergency care provider and the insurer or administrator are equally responsible for scheduling the informal settlement teleconference.

(e) Makes a conforming change.

SECTION 9. Amends Sections 1467.055(d), (g), (h), and (i), Insurance Code, as follows:

(d) Requires a mediation, at the beginning of mediation, to inform the enrollee, if the enrollee is participating in the mediation in person, that if the enrollee is not satisfied with the mediated agreement, the enrollee may file a complaint with TMB or other appropriate regulatory agency against the facility-based provider or emergency care provider for improper billing, rather than the TMB against the facility-based physician for improper billing. Makes no further changes to this subsection.

(g) Requires that a mediation, except as the request of an enrollee or as otherwise agreed by all parties, be held not later than the 180th day after the date of the request for mediation.

(h) Makes a conforming change.

(i) Prohibits a health care or medical service provided by a facility-based provider or emergency care provider, rather than facility-based physician, from being summarily disallowed. Makes no further changes to this subsection.

SECTION 10. Amends Sections 1467.056(a), (b), and (d), Insurance Code, to make conforming changes.

SECTION 11. Amends Section 1467.057(a), Insurance Code, to include other appropriate regulatory agency in the list of certain entities the mediator of an unsuccessful mediation is required to report the outcome to.

SECTION 12. Amends Section 1467.058, Insurance Code, to make a conforming change.

SECTION 13. Amends Section 1467.059, Insurance Code, to make a conforming change.

SECTION 14. Amends Section 1467.060, Insurance Code, to make a conforming change.

SECTION 15. Amends Section 1467.101(c), Insurance Code, to make a conforming change.

SECTION 16. Amends Section 1467.151, Insurance Code, as follows:

Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) Requires the commissioner and TMB or other regulatory agency, as appropriate, to adopt certain rules. Sets forth certain requirements for the adopted rules, including that they distinguished among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed health care or medical care.

(b) Makes conforming and nonsubstantive changes.

(c) and (d) Makes conforming changes.

SECTION 17. Makes application of this Act prospective to January 1, 2018.

SECTION 18. Effective date: September 1, 2017.