The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1467.001. DEFINITIONS. In this chapter:

(1) "Administrator" means:
   (A) an administering firm for a health benefit plan providing coverage under Chapter 1551, 1575, or 1579; 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.

(2-a) "Emergency care" has the meaning assigned by Section 1301.155.

(2-b) "Emergency care provider" means a physician, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care.

(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, 1575, or 1579.

(3-a) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(4) "Facility-based provider" means a physician, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility.

(4-a) "Health care practitioner" means an individual who is licensed to provide health care services.

(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 provider or emergency care provider or the provider's representative to settle a health benefit claim of an enrollee.

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 4, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 1, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 139 (H.B. 1428), Sec. 1, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

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

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

(2) an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 2, eff.
Sec. 1467.003. RULES. The commissioner, the Texas Medical Board, any other appropriate regulatory agency, and the chief administrative law judge shall adopt rules as necessary to implement their respective powers and duties under this chapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 3, eff. September 1, 2017.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

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 provider or emergency care provider from, at any time, offering a reformed charge for health care or medical services or supplies.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1,
Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 4, eff. September 1, 2017.

SUBCHAPTER B. MANDATORY MEDIATION

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

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 provider or emergency care provider, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $500; and

(2) the health benefit claim is for:

(A) emergency care; or

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator.

(b) Except as provided by Subsections (c) and (d), if an enrollee requests mediation under this subchapter, the facility-based provider or emergency care provider, or the provider'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 provider shall, before providing a health care or medical service or supply, provide a complete disclosure to an enrollee that:

(1) explains that the facility-based provider 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 provider 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.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 467 (S.B. 481), Sec. 5, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 5, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1467.0511. NOTICE AND INFORMATION PROVIDED TO ENROLLEE. (a) A bill sent to an enrollee by a facility-based provider or emergency care provider or an explanation of benefits sent to an enrollee by an insurer or administrator for an out-of-network health benefit claim eligible for mediation under this chapter must contain, in not less than 10-point boldface type, a conspicuous, plain-language explanation of the mediation process available under this chapter, including information on how to request mediation and a statement that is substantially similar to the following:

"You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at (website) and (phone number)."

(b) If an enrollee contacts an insurer, administrator, facility-based provider, or emergency care provider about a bill that may be eligible for mediation under this chapter, the insurer, administrator, facility-based provider, or emergency care provider is encouraged to:
(1) inform the enrollee about mediation under this chapter; and

(2) provide the enrollee with the department's toll-free telephone number and Internet website address.

Added by Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 6, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264 and HB1742, 86th Legislature, Regular Session, for amendments affecting the following section.

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

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

(c) A person may not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship 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.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 7, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264 and HB1742, 86th Legislature, Regular Session, for amendments affecting the following section.

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

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

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

(d) The mediator’s fees shall be split evenly and paid by the insurer or administrator and the facility-based provider or emergency care provider.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 8, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264 and HB1742, 86th Legislature, Regular Session, for amendments affecting the following section.

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

(b) A request for mandatory mediation must be provided 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 provider or emergency care provider 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 provider or emergency care provider and insurer or administrator of the request.

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

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

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:
Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 9, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264 and HB1742, 86th Legislature, Regular Session, for amendments affecting the following section.

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

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

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

(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 file a complaint with:

(1) the Texas Medical Board or other appropriate regulatory agency against the facility-based provider or emergency care provider for improper billing; and

(2) the department for unfair claim settlement practices.

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

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

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

(h) 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 provider or emergency care provider 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 health care or medical service or supply provided by a facility-based provider or emergency care provider may not be summarily disallowed. This subsection does not require an insurer or administrator to pay for an uncovered service or supply.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 10, eff.
The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

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

(1) evaluate whether:

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

(B) the amount paid by the insurer or administrator represents the usual and customary rate for the health care or medical service or supply 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 provider or emergency care provider.

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

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

(d) The goal of the mediation is to reach an agreement among the enrollee, the facility-based provider or emergency care provider, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based provider or emergency care provider, the amount charged by the facility-based provider or emergency care provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1,
sec. 1467.057. NO AGREED RESOLUTION. (a) The mediator of an unsuccessful mediation under this chapter shall report the outcome of the mediation to the department, the Texas Medical Board or other appropriate regulatory agency, and the chief administrative law judge. 

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

1. names the special judge on whom the parties agreed or appoints the special judge if the parties did not agree on a judge;

2. states the issues to be referred and the time and place on which the parties agree for the trial;

3. requires each party to pay the party's proportionate share of the special judge's fee; and

4. certifies that the parties have waived the right to trial by jury.

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:
Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral is made under Section 1467.057, the facility-based provider or emergency care provider and the insurer or administrator 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.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 13, eff. September 1, 2017.

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 provider or emergency care provider, after copayments, deductibles, and coinsurance; and

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 14, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1467.058. CONTINUATION OF MEDIATION. After a referral is made under Section 1467.057, the facility-based provider or emergency care provider and the insurer or administrator 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.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 13, eff. September 1, 2017.

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

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 provider or emergency care provider, after copayments, deductibles, and coinsurance; and

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 14, eff. September 1, 2017.
publication of the current statutes, see S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1467.060. REPORT OF MEDIATOR. The mediator shall report to the commissioner and the Texas Medical Board or other appropriate regulatory agency:

(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.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 15, eff. September 1, 2017.

SUBCHAPTER C. BAD FAITH MEDIATION

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

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

(1) failing to participate in the mediation;

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

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 17, eff. September 1, 2017.
The following section was amended by the 86th Legislature. Pending publication of the current statutes, see S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

The following section was amended by the 86th Legislature. Pending publication of the current statutes, see HB1742 and S.B. 1264, 86th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1467.151. CONSUMER PROTECTION; RULES. (a) The commissioner and the Texas Medical Board or other regulatory agency, 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 health care or 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 or other appropriate regulatory agency 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 that gave rise to the dispute;

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

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

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

(E) any other information about:

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

(ii) the facility-based provider or emergency care provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.

(c) The information collected and maintained by the department and the Texas Medical Board and other appropriate regulatory agencies under Subsection (b)(2) is public information as defined by Section 552.002, Government Code, and may not include personally identifiable information or health care or medical information.

(d) A facility-based provider or emergency care provider who fails to provide a disclosure under Section 1467.051 or 1467.0511 is not subject to discipline by the Texas Medical Board or other appropriate regulatory agency for that failure and a cause of
action is not created by a failure to disclose as required by Section 1467.051 or 1467.0511.

Added by Acts 2009, 81st Leg., R.S., Ch. 1290 (H.B. 2256), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 100 (S.B. 507), Sec. 16, eff. September 1, 2017.