INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

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, 1575, or 1579; and

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

(1-a) "Arbitration" means a process in which an impartial arbiter issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim.

(2) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(2), eff. September 1, 2019.

(2-a) "Diagnostic imaging provider" means a health care provider who performs a diagnostic imaging service on a patient for a fee or interprets imaging produced by a diagnostic imaging service.

(2-b) "Diagnostic imaging service" means magnetic resonance imaging, computed tomography, positron emission tomography, or any hybrid technology that combines any of those imaging modalities.

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

(2-d) "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 health benefit plan subject to this chapter.

(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.

(4-b) "Laboratory service provider" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a physician who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

(5) "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the health benefit plan issuer or the administrator and an out-of-network 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.

(6-a) "Out-of-network provider" means a diagnostic imaging provider, emergency care provider, facility-based provider, or laboratory service provider that is not a participating provider for a health benefit plan.

(7) "Party" means a health benefit plan issuer offering a health benefit plan, an administrator, or an out-of-network provider or the provider's representative who participates in a mediation or arbitration conducted 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 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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.01, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(2), eff. September 1, 2019.

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

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843;

(2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and

(3) 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. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 139 (H.B. 1428), Sec. 2, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.02, eff. September 1, 2019.

Sec. 1467.003. RULES. (a) The commissioner, the Texas Medical Board, and any other appropriate regulatory agency shall adopt rules as necessary to implement their respective powers and duties under this chapter.

(b) Section 2001.0045, Government Code, does not apply to a rule adopted 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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.02,

eff. September 1, 2019.

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) a health benefit plan issuer or administrator from, at any time, offering a reformed claim settlement; or

(2) an out-of-network 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, eff. June 19, 2009.

Amended by:

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

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.02, eff. September 1, 2019.

Sec. 1467.006. BENCHMARKING DATABASE. (a) In this section, "geozip area" means an area that includes all zip codes with identical first three digits. For purposes of this section, a health care or medical service or supply provided at a location that does not have a zip code is considered to be provided in the geozip area closest to the location at which the service or supply is provided.

(b) The commissioner shall select an organization to maintain a benchmarking database in accordance with this section. The organization may not:

(1) be affiliated with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider; or

(2) have any other conflict of interest.

(c) The benchmarking database must contain information necessary to calculate, with respect to a health care or medical service or supply, for each geozip area in this state:

(1) the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and

(2) the 50th percentile of rates paid to participating providers who are not facilities.

(d) The commissioner may adopt rules governing the submission of information for the benchmarking database described by Subsection (c).

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.03, eff. September 1, 2019.

SUBCHAPTER B. MANDATORY MEDIATION FOR OUT-OF-NETWORK FACILITIES

Sec. 1467.050. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider that is a facility.

(b) This subchapter does not apply to a health benefit claim for the professional or technical component of a physician service.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.05, eff. September 1, 2019.

Sec. 1467.0505. ESTABLISHMENT AND ADMINISTRATION OF MEDIATION PROGRAM. (a) The commissioner shall establish and administer a mediation program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program, including the establishment of a portal on the department's Internet website through which a request for mediation under Section 1467.051 may be submitted; and

(2) shall maintain a list of qualified mediators for the program.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec.

2.05, eff. September 1, 2019.

Sec. 1467.051. AVAILABILITY OF MANDATORY MEDIATION. (a) An out-of-network provider or a health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:

(1) there is an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee may not be billed; and

(2) the health benefit claim is for:

(A) emergency care;

(B) an out-of-network laboratory service; or

(C) an out-of-network diagnostic imaging service.

(b) If a person requests mediation under this subchapter, the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the mediation.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(3), eff. September 1, 2019.

(d) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(3), eff. September 1, 2019.

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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.06, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.07, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(3), eff. September 1, 2019.

Sec. 1467.052. MEDIATOR QUALIFICATIONS. (a) Except as provided by Subsection (b), to qualify for an appointment as a mediator under this subchapter 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 commissioner.

(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 a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider during the three years immediately preceding the request for mediation.

(d) The commissioner shall immediately terminate the approval of a mediator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as a mediator.

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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.08, eff. September 1, 2019.

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

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(5), eff. September 1, 2019.

(b-1) If the parties do not select a mediator by mutual agreement on or before the 30th day after the date the mediation is requested, the party requesting the mediation shall notify the commissioner, and the commissioner shall select a mediator from the commissioner's list of approved mediators.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(5), eff. September 1, 2019.

(d) The mediator's fees shall be split evenly and paid by the health benefit plan issuer or administrator and the out-of-network 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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.09, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(5), eff. September 1, 2019.

Sec. 1467.054. REQUEST AND PRELIMINARY PROCEDURES FOR MANDATORY MEDIATION. (a) An out-of-network provider or a health benefit plan issuer or administrator may request mandatory mediation under this subchapter.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(6), eff. September 1, 2019.

(b-1) The person who requests the mediation shall provide written notice on the date the mediation is requested in the form and manner provided by commissioner rule to:

(1) the department; and

(2) each other party.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(6), eff. September 1, 2019.

(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 a person submits a request for mediation under this subchapter.

(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) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B.

1264), Sec. 3.03(6), eff. September 1, 2019.

(g) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(6), eff. September 1, 2019.

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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.10, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(6), eff. September 1, 2019.

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.

(c-1) Information submitted by the parties to the mediator is confidential and not subject to disclosure under Chapter 552, Government Code.

(d) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(7), eff. September 1, 2019.

(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) A mediation shall be held not later than the 180th day after the date of the request for mediation.

(h) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(7), eff. September 1, 2019.

(i) A health care or medical service or supply provided by an out-of-network provider may not be summarily disallowed. This subsection does not require a health benefit plan issuer 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.

(k) On agreement of all parties, any deadline under this subchapter may be extended.

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. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.11, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(7), eff. September 1, 2019.

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

(1) the amount charged by the out-of-network provider for the health care or medical service or supply is excessive; and

(2) the amount paid by the health benefit plan issuer or administrator represents the usual and customary rate for the health care or medical service or supply or is unreasonably low.

(b) The out-of-network provider may present information regarding the amount charged for the health care or medical service or supply. The health benefit plan issuer or administrator may present information regarding the amount paid by the issuer 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 between the out-of-network provider and the health benefit plan issuer or administrator, as applicable, as to the amount paid by the issuer or administrator to the out-of-network provider and the amount charged by the out-of-network 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. 11, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.12, eff. September 1, 2019.

Sec. 1467.0575. RIGHT TO FILE ACTION. Not later than the 45th day after the date that the mediator's report is provided to the department under Section 1467.060, either party to a mediation for which there was no agreement may file a civil action to determine the amount due to an out-of-network provider. A party may not bring a civil action before the conclusion of the mediation process under this subchapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.13, eff. September 1, 2019.

Sec. 1467.060. REPORT OF MEDIATOR. Not later than the 45th day after the date the mediation concludes, 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.

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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.14, eff. September 1, 2019.

SUBCHAPTER B-1. MANDATORY BINDING ARBITRATION FOR OTHER PROVIDERS

Sec. 1467.081. APPLICABILITY OF SUBCHAPTER. This subchapter applies only with respect to a health benefit claim submitted by an out-of-network provider who is not a facility.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec.

2.15, eff. September 1, 2019.

Sec. 1467.082. ESTABLISHMENT AND ADMINISTRATION OF ARBITRATION PROGRAM. (a) The commissioner shall establish and administer an arbitration program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

(b) The commissioner:

(1) shall adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program, including the establishment of a portal on the department's Internet website through which a request for arbitration under Section 1467.084 may be submitted; and

(2) shall maintain a list of qualified arbitrators for the program.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.083. ISSUE TO BE ADDRESSED; BASIS FOR DETERMINATION. (a) The only issue that an arbitrator may determine under this subchapter is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider.

(b) The determination must take into account:

(1) whether there is a gross disparity between the fee billed by the out-of-network provider and:

(A) fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and

(B) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;

(2) the level of training, education, and experience of the out-of-network provider;

(3) the out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;

(4) the circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply;

(5) individual enrollee characteristics;

(6) the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database described by Section 1467.006;

(8) the history of network contracting between the parties;

(9) historical data for the percentiles described by Subdivisions (6) and (7); and

(10) an offer made during the informal settlement teleconference required under Section 1467.084(d).

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.084. AVAILABILITY OF MANDATORY ARBITRATION. (a) Not later than the 90th day after the date an out-of-network provider receives the initial payment for a health care or medical service or supply, the out-of-network provider or the health benefit plan issuer or administrator may request arbitration of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:

(1) there is a charge billed by the provider and unpaid by the issuer or administrator after copayments, coinsurance, and deductibles for which an enrollee may not be billed; and

(2) the health benefit claim is for:

(A) emergency care;

(B) a health care or medical service or supply provided by a facility-based provider in a facility that is a participating provider;

(C) an out-of-network laboratory service; or

(D) an out-of-network diagnostic imaging service.

(b) If a person requests arbitration under this subchapter, the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the arbitration.

(c) The person who requests the arbitration shall provide written notice on the date the arbitration is requested in the form and manner prescribed by commissioner rule to:

(1) the department; and

(2) each other party.

(d) In an effort to settle the claim before arbitration, all parties must participate in an informal settlement teleconference not later than the 30th day after the date on which the arbitration is requested. A health benefit plan issuer or administrator, as applicable, shall make a reasonable effort to arrange the teleconference.

(e) The commissioner shall adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding. The rules must provide that:

(1) the total amount in controversy for multiple claims in one proceeding may not exceed $5,000; and

(2) the multiple claims in one proceeding must be limited to the same out-of-network provider.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.085. EFFECT OF ARBITRATION AND APPLICABILITY OF OTHER LAW. (a) Notwithstanding Section 1467.004, an out-of-network provider or health benefit plan issuer or administrator may not file suit for an out-of-network claim subject to this chapter until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

(b) An arbitration conducted under this subchapter is not subject to Title 7, Civil Practice and Remedies Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.086. SELECTION AND APPROVAL OF ARBITRATOR. (a) If the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is requested, the party requesting the arbitration shall notify the commissioner, and the commissioner shall select an arbitrator from the commissioner's list of approved arbitrators.

(b) In selecting an arbitrator under this section, the commissioner shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

(c) In approving an individual as an arbitrator, the commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an arbitration. A conflict of interest includes current or recent ownership or employment of the individual or a close family member in any health benefit plan issuer or administrator or physician, health care practitioner, or other health care provider.

(d) The commissioner shall immediately terminate the approval of an arbitrator who no longer meets the requirements under this subchapter and rules adopted under this subchapter to serve as an arbitrator.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.087. PROCEDURES. (a) The arbitrator shall set a date for submission of all information to be considered by the arbitrator.

(b) A party may not engage in discovery in connection with the arbitration.

(c) On agreement of all parties, any deadline under this subchapter may be extended.

(d) Unless otherwise agreed to by the parties, an arbitrator may not determine whether a health benefit plan covers a particular health care or medical service or supply.

(e) The parties shall evenly split and pay the arbitrator's

fees and expenses.

(f) Information submitted by the parties to the arbitrator is confidential and not subject to disclosure under Chapter 552, Government Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.088. DECISION. (a) Not later than the 51st day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

(1) determines whether the billed charge or the payment made by the health benefit plan issuer or administrator, as those amounts were last modified during the issuer's or administrator's internal appeal process, if the provider elects to participate, or the informal settlement teleconference required by Section 1467.084(d), as applicable, is the closest to the reasonable amount for the services or supplies determined in accordance with Section 1467.083(b); and

(2) selects the amount determined to be closest under Subdivision (1) as the binding award amount.

(b) An arbitrator may not modify the binding award amount selected under Subsection (a).

(c) An arbitrator shall provide written notice in the form and manner prescribed by commissioner rule of the reasonable amount for the services or supplies and the binding award amount. If the parties settle before a decision, the parties shall provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement. The department shall maintain a record of notices provided under this subsection.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

Sec. 1467.089. EFFECT OF DECISION. (a) An arbitrator's decision under Section 1467.088 is binding.

(b) Not later than the 45th day after the date of an arbitrator's decision under Section 1467.088, a party not satisfied

with the decision may file an action to determine the payment due to an out-of-network provider.

(c) In an action filed under Subsection (b), the court shall determine whether the arbitrator's decision is proper based on a substantial evidence standard of review.

(d) Not later than the 30th day after the date of an arbitrator's decision under Section 1467.088, a health benefit plan issuer or administrator shall pay to an out-of-network provider any additional amount necessary to satisfy the binding award.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.15, eff. September 1, 2019.

SUBCHAPTER C. BAD FAITH PARTICIPATION

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

(1) failing to participate in the informal settlement teleconference under Section 1467.084(d) or an arbitration or mediation under this chapter;

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

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

(b) Failure to reach an agreement under Subchapter B is not conclusive proof of bad faith participation.

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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.16, eff. September 1, 2019.

Sec. 1467.102. PENALTIES. (a) Bad faith participation or otherwise failing to comply with Subchapter B-1 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 participation under Subchapter B, 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.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.16, eff. September 1, 2019.

SUBCHAPTER D. COMPLAINTS; CONSUMER PROTECTION

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

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

(b) The department and the Texas Medical Board or other appropriate regulatory agency shall maintain information on each complaint filed that concerns a claim, arbitration, or mediation subject to this chapter, including:

(1) the type of services or supplies that gave rise to the dispute;

(2) the type and specialty, if any, of the out-of-network provider who provided the out-of-network service or supply;

(3) the county and metropolitan area in which the

health care or medical service or supply was provided;

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

(5) any other information about:

(A) the health benefit plan issuer or administrator that the commissioner by rule requires; or

(B) the out-of-network provider that the Texas Medical Board or other appropriate regulatory agency by rule requires.

(c) The information collected and maintained under Subsection (b) 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) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(11), eff. September 1, 2019.

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.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 2.17, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 3.03(11), eff. September 1, 2019.