Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

July 15, 2019

RE: Rulemaking Re: Senate Bill 1264 Rules

Via email: comments@tdi.texas.gov

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related healthcare entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

TAHP appreciates the Department of Insurance (TDI) seeking input and scheduling a stakeholder meeting regarding its upcoming rulemaking to implement Senate Bill 1264. We offer the following comments to the issues raised in the TDI meeting notice:

Issue 1: Nonemergency exemption

SB 1264 allows a consumer to be balance billed for out-of-network nonemergency care if the provider gives the consumer "a complete written disclosure" that includes projected costs before providing the service.

For consideration: What rules, if any, are needed to provide adequate consumer certainty and protection?

- **Should TDI rules define timelines for how much advance notice consumers must be given before receiving a service that may result in a balance bill?**

TAHP Response:

TAHP recommends that TDI rules provide for a minimum time frame for advance notice for the disclosures required for an out-of-network (OON) provider to avoid SB 1264's balance billing prohibition. The timing of the disclosures and consent is critical to ensure enrollees have sufficient time to consider the information, ask questions, and make these important health care and financial decisions. We recommend a requirement that the disclosure and election document be presented when the non-network service is scheduled (or as soon as feasible after scheduling, within no more than 2 or 3 business days), **and in no case later than 3 business days prior to the proposed treatment/procedure.**

It is often the case that enrollees are presented with a stack of consent and permission forms just before planned procedures. To provide the disclosures regarding network status and costs and

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present the election to receive out-of-network services just hours (or maybe minutes) before a procedure is not meaningful and would pressure the enrollee to agree. (See the discussion on "duress" below.) The enrollee has set time aside for the procedure and may have arranged for relatives or friends to aid in transportation and support. To reject the use of an out-of-network provider, such as a neuromonitoring technician or assistant surgeon, at that moment could result in a need to reschedule the procedure and real losses for the enrollee, such as lost wages, the use of earned sick time, etc.

The potential pitfalls to allowing a "loophole" to surprise balance billing protections were anticipated by the Brookings Institution in their 2019 report on surprise billing.[1] On page 13 of their report, they say an exception that is too broad, "may … thwart surprise billing protections…." That report expressed concern that, "Given the amount of paperwork patients typically must fill out when obtaining medical care and the worry and pain involved with their illness, the notice of potentially high out-of-network billing charges may not be salient enough for patients to take notice. Additionally, the notice might be provided at a point where patients lack realistic alternatives." This is precisely TAHP's concern and why we strongly argue the written disclosures and elections to receive care out-of-network must be separated from typical "morning of service" consents.

- **What specific information must the disclosure include to ensure consumers understand the potential out-of-pocket cost for the service?**

TAHP Response:

Disclosure and election document(s) must be required for *each* out-of-network practitioner and must be specific to *the services* to be provided to *the enrollee*. A single document that purports to broadly memorialize the enrollee's election to permit treatment by unnamed out-of-network practitioners or a class of practitioner should be specifically disallowed by TDI rules as it does not meet the requirements of SB 1264. The text of the Act mandates the enrollee to elect to receive a service with respect to each provider. For instance, currently many surgical medical consent documents elicit assent to treatment for "any such associates, technical assistants, and other health care providers, to perform such other procedures, which are advisable" in the surgeon's professional judgment. An attempt to obtain an election to receive out-of-network care with a similar document/phrase simply does not meet the requirements or intent of the law.

The disclosures by practitioners who may have the opportunity to utilize the exception to the surprise billing prohibition (non-emergency services only) must also be **specific to the enrollee and that person's proposed care**.

[1] State Approaches to Mitigating Surprise Out-of-Network Billing; February 19, 2019.

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Senate Bill 1264 does not permit the use of blanket disclosures or references to generalities if a practitioner is to avoid the prohibition. Each non-network physician or provider that wishes to balance bill must demonstrate that the enrollee elected, in advance and in writing, to receive the specific services from that provider, after receiving a "complete written disclosure." The required disclosure cannot be a general statement that a service typically costs a certain amount but is a projection only specific to the services to be provided to that enrollee.

The purpose of the mandated disclosures is to avoid "surprise" balance bills, so the disclosures must be specific enough that the enrollee will not be surprised by the balance bill that it will receive from the non-network provider after the service. As required by SB 1264, a "complete written disclosure" statement should include, at a minimum:

- A statement that the provider is not in-network with the enrollee's health benefit plan;
- A good faith estimate of total billed charges for the proposed service;
- A good faith estimate of the enrollee's total potential liability, specifying:
  - cost-sharing under the enrollee's health benefit plan (applicable coinsurance, copayment, and deductible amounts) and
  - the enrollee's additional liability after health plan benefits (i.e., the "balance billing" amount);
- A statement that actual charges and enrollee costs may vary based on the patient's medical condition and other factors associated with performance of the services;
- An explanation of the circumstances under which the provider will bill, and the enrollee would be responsible for those amounts; and,
- Options for seeking care from a different provider.

TAHP recommends that TDI promulgate within its rules clear and specific "form" language that must be used for the disclosures and elections, with the non-network providers simply adding in the applicable estimate amounts. This would allow patient/enrollees to become familiar with a standard document and create greater understanding of what this disclosure means across out-of-network providers. Out-of-network providers should be required to present this document separately and not be permitted to incorporate its provisions as part of another document. The enrollee must acknowledge by signature receipt of the required complete written disclosure. The rules should also require the out-of-network provider to submit a copy of the disclosure and signed election as part of the claim or upon request of the enrollee or health plan.

TAHP also recommends that the rules ensure the that the obvious intent of the disclosures – to prevent *surprise* balance billing – is met by prohibiting the out-of-network providers from balance billing enrollees any more than the projected costs provided to the enrollee in the disclosure.

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TAHP also recommends that the rules clarify that SB 1264 does not create any new mandated benefits and require that the disclosures accurately reflect an enrollee's potential responsibility for full billed charges for non-covered services. For example, SB 1264's payment mandate applies to a non-network lab or diagnostic imaging service performed "in connection with" a network service only if it is a "covered" service. Most HMO and EPO health benefit plans provide out-of-network benefits only for emergencies and when a network provider is not available to cover the service, so a non-network lab or diagnostic imaging service performed "in connection with" a network service may not be covered by the benefit plan if a network provider was available to perform the service. A non-network provider who intends to bill an enrollee the full billed charge for a non-covered service should be required to inform the enrollee of that fact and disclose the amount.

- **What rules should TDI consider to prevent consumers from getting disclosures when they may be under duress?**

TAHP Response:

As discussed above, TAHP strongly recommends that the "complete written disclosures" and enrollee elections to receive out-of-network services be provided to enrollees at least 3 business days prior to a service being performed. We believe that providing enrollees with sufficient time to consider and act upon the required information is critical to reduce the potential and mitigate the impact of duress that could lead to "surprise" balance bills. Additionally, where an "elective" procedure is scheduled less than 3 business days in advance, the enrollee would likely experience pressure and duress to agree to any provider requirements in order to complete the procedure, and so the option for an out-of-network provider to make the disclosures and be able to balance bill the enrollee should not be available in this situation.

For these reasons, we also recommend that the rules specify that this option is not available for care following stabilization of an emergency, or at least clarify that the same advance notice requirements apply.

Issue 2: Arbitration process.

SB 1264 requires the arbitrator to provide the parties with a written decision no later than the 51st day after arbitration is requested, unless both parties agree to extend the deadline.

For consideration: What rules, if any, are needed to ensure procedural fairness and meet the strict deadlines set by SB 1264?

- **Are there existing arbitration processes or models that should be considered?**

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TAHP recommends consideration of the Washington arbitration process, which considers the final offer from the payor and provider extended during informal dispute resolution rather than the original billed charges and allowable amount, as a way to ensure both parties participate and stay engaged in the process. This is a strong incentive to actively participate in informal dispute resolution and provides the greatest opportunity for these matters to be solved prior to arbitration.

With regard to the specific procedures to be used in the arbitration, TAHP recommends that TDI and stakeholders review arbitration procedures already established by other organizations such as the American Arbitration Association, the Association for Conflict Resolution, the American Bar Association Dispute Resolution Section, the State Bar of Texas Alternative Dispute Resolution Section, or the Texas Arbitration Council.

- **To what extent should the process provide each party with an opportunity to rebut the information another party submitted to an arbitrator?**

TAHP Response:

TAHP recommends that there be some opportunity to rebut information submitted by the other party. We recommend that the rules require each party to provide the other with copies of any information submitted to the arbitrator at the time that it is submitted to the arbitrator and with sufficient time for the arbitrator and other party to review. To the extent either party wants to submit additional information, it should be limited by rule to information used only for the purpose of rebutting information presented by the other party. TDI rules should not limit what type of information can be submitted to the arbitrator. We believe a complete prior disclosure of information will allow all parties to present a complete picture of its position to the arbitrator, and perhaps give the parties the greatest opportunity to resolve the matter prior to arbitration.

The rules should allow equal weight to be given to all evidence and information submitted by the parties. The arbitrator should be able assign the appropriate value to all information presented. No TDI rules should artificially weigh any one type of class of information. The arbitrations will be fact-specific, and latitude should be given to the arbitrator based on the facts at issue.

We also recommend that the rules require any settlement offers that a party wishes to submit for consideration by the arbitrator must be made to the other party in writing.

New section 1467.083 allows arbitrators to consider individual enrollee characteristics when making their determination. We suggest that the rules provide guidance to ensure arbitrators uniformly take these factors into consideration in an objective and consistent manner.

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- **Are rules needed to address how and when the parties must notify TDI if they cannot agree on an arbitrator?**

TAHP Response: TAHP recommends that the rules require the party that requested arbitration to notify TDI by the 30th day (or sooner) after the request if there is no agreement on the arbitrator. If feasible, the notice could be provided via the TDI portal. We suggest a process whereby the notice could be provided sooner and TDI would propose five arbitrators and give each party an opportunity to strike two each.

- **Are rules needed to address fees and standards for arbitrators?**

TAHP Response: TAHP recommends that the TDI rules establish a rate/fee schedule be and parameters under which arbitrators must notify the parties if they are expending excessive hours on the preparation for an arbitration. We also recommend that arbitrators be allowed to require an advance retainer or deposit amount to ensure payment is received.

Issue 3: Payment standards and hold harmless provisions

SB 1264 does not address nonemergency situations where a network provider is not reasonably available. In these situations, a health plan uses an access plan to address gaps in its contracted network. Current TDI rules establish payment standards for these situations to minimize balance billing to consumers and prohibit balance billing for HMO members.

For consideration: What, if any, changes should be made to TDI rules for access plans to ensure consumers are protected from balance billing resulting from gaps in a health plan's contracted network?

TAHP Response:

First, we would like to point out that SB 1264 does not address network access plans specifically or network access or adequacy in general. SB 1264 was enacted as a consumer protection against out-of-network surprise balance billing. Surprise balance billing problems are not caused by "network access" issues. TAHP has discussed with TDI on many occasions its position that the network access filing requirements are overly burdensome and do not serve their intended purposes and will not restate them here because they are not relevant to SB 1264. We will note that it is a fairly rare occurrence that an out-of-network provider performs services because a network provider is not available. As TDI is aware, the vast majority of existing network "gaps" are based on a complete lack of available licensed providers, and in that situation enrollees generally choose to see network providers that are available outside of the immediate area. Additionally, many health plans attempt to enter into "single-case" agreements in the limited situation where there are non-network providers available to fill a network mileage "gap."

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Despite many claims by practitioner stakeholders, there is *little evidence* that network rules have a meaningful impact on out-of-network surprise billing activities. According to the Brookings Institution, "… a network adequacy standard for facility-based clinicians would not do anything to address the market failure that leads to surprise out-of-network billing. Network adequacy regulation would strengthen the incentive for insurers to bring these providers into their networks, *but surprise bills arise because of the incentives that providers (not insurers) face.*"[2] Texas has experienced, as has the rest of the nation, consolidation among practitioners. Dr. Vivian Ho, in written testimony before the Texas Senate Business and Commerce Committee, stated that a "2015 Texas Tribune article mentions that U.S. Anesthesia Partners has [over] 1,000 doctors. The Texas Medical Association estimates that there are 3,500 practicing anesthesiologists in the state."[3] It is provider consolidation, provider business practices, and the out-of-network payment mandates that compounds the issue of surprise billing in Texas.

In any event, network adequacy and claims settlement are two separate topics and TDI rules should not conflate the issues.

Senate Bill 1264 has supplanted the regulatory framework adopted by TDI at 28 Texas Administrative Code sections 3.3708(b)(1), 3.3708(b)(3), 3.3708(e), 3.3725 (d)-(e), and 11.1611(d) and these provisions should be repealed.

First and foremost, Senate Bill 1264 establishes a statutory "hold harmless" provision by prohibiting surprise billing by providers and practitioners. See new Texas Insurance Code §§ 1271.155 (g), 1271.157 (c), 1301.164 (c), and 1301.165 (c) as added by SB 1264. Thus, the regulatory mandate in sections 11.1611(d) and 3.3725 that HMO and EPO plans must ensure the insured/enrollee is "held harmless" is contrary to the plain language and the clear intent of SB 1264. Providers and practitioners, under the circumstances provided in the law, are prohibited from surprise billing.

Senate Bill 1264 expressly establishes that the standard for applicable out-of-network claims for preferred provider benefit ("PPO") plans is "the usual and customary rate or at an agreed rate" at the in-network benefit level of coverage. This supplements the current HMO and EPO statutory standards, which are also "the usual and customary rate or at an agreed rate." The legislature confirmed that "usual and customary rate does not equal "usual and customary charge" in adopting SB 1264.

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[2] See, "The relationship between network adequacy and surprise billing" at https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/05/10/the-relationship-between-network-adequacy-and-surprise-billing/ posted on May 10, 2019. (emphasis added).

[3] Testimony of Vivian Ho, PhD, James A. Baker III Institute Chair in Health Economics, Rice University Baylor College of Medicine, Before the Senate Committee on Business and Commerce On "Healthcare Industry Consolidation and its Impact on Market Competition and Health Insurance," December 10, 2018. Internal citation omitted.

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Although SB 1264 does not specifically address non-emergency situations where a network provider is not available, the provisions and legislative intent behind SB 1264 plainly demonstrate that the Insurance Code provisions addressing this situation that have been cited by TDI as legislative authority for these rules do not support the current regulatory payment mandates and TDI should not maintain these erroneous rules, even for this limited situation. Repeal of the payment mandates will "even the playing field" and may increase the likelihood that a provider who is the only one of their type or specialty in an area will be willing to negotiate to be in health plan networks, further reducing the chance of out-of-network services.

Issue 4: Benchmarking

SB 1264 provides that the Insurance Commissioner may adopt rules governing the submission of information for the benchmarking database.

For consideration: What rules, if any, are needed related to submissions of information to the benchmarking database and how that information is used? For example, are rules needed to define regions as they pertain to the requirement that the arbitrator consider "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*."

TAHP Response:

TDI recommends that it, at least to the extent possible, leverage the de-identified claims information that health plans are already required to annually report to prepare the health care pricing guide https://texashealthcarecosts.org/faqs/. This claims data could be used to create the benchmarking databases in a much more efficient and less costly manner than contracting with an external entity that may or may not have data adequately representing market rates. There are issues with most of the currently available commercial databases. (For example, Fair Health's claims data does not include actual in-network allowed amounts.)

It is important that the data used in the creation of benchmark databases include charges and payments by providers and plans covering patients who receive insurance through federal marketplace/exchange plans. Some commercially available "benchmarking databases" are overly limited in the payer and plan types used as sources and so are not fair representations of market payments.

If TDI does want to explore using commercial databases, it should do so in a public review and issue Requests for Information and Requests for Proposals that will allow consideration of the validity, advantages, and disadvantages of each database. Any database used must be transparent about the sources of the data included.

In general, we want the data to be statistically valid. In particular, we want enough data that the

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distribution is not skewed by a handful of providers charging excessive amounts. A primary concern is that the regions be large enough to ensure that there is enough data on the types of procedures where balance billing is most likely to occur.

TAHP recommends the following areas or "regions" (currently used for Marketplace plans):

Area 1	Callahan, Jones, Taylor
Area 2	Armstrong, Carson, Potter, Randall
Area 3	Bastrop, Caldwell, Hays, Travis, Williamson
Area 4	Hardin, Jefferson, Orange
Area 5	Cameron
Area 6	Brazos, Burleson, Robertson
Area 7	Aransas, Nueces, San Patricio
Area 8	Collin, Dallas, Delta, Denton, Ellis, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, Wise
Area 9	El Paso
Area 10	Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, San Jacinto, Montgomery, Waller
Area 11	Bell, Coryell, Lampasas
Area 12	Webb
Area 13	Gregg, Rusk, Upshur
Area 14	Crosby, Lubbock
Area 15	Hidalgo
Area 16	Midland
Area 17	Ector
Area 18	Irion, Tom Green
Area 19	Atascosa, Bandera, Bexar, Comal, Guadalupe, Medina, Kendall, Wilson
Area 20	Grayson
Area 21	Bowie
Area 22	Smith
Area 23	Calhoun, Victoria
Area 24	McLennan
Area 25	Archer, Clay, Witchita
Area 26	All remaining Counties

Regarding the methodology used for the databases, the National Bureau of Economic Research

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(NBER) has published a large-scale review of emergency room claims from across the country and has published its methodology for aggregating and fairly presenting emergency medical service payment data. Further, because the vast majority of emergency department visits use a limited number of codes, TDI could fairly easily compile data on this very limited set of codes to develop annual benchmarks using the NBER methodology.[4]

Lastly, TAHP recommends that collection of data distinguish between plan types (HMO vs PPO).

Issue 5: Other considerations

Are there other issues or considerations that TDI should be aware of when drafting rules related to SB 1264? Please be as thorough as possible in your responses to ensure all relevant information is considered as the agency develops rules in time for the law's January 1, 2020, effective date.

TAHP Response:

TAHP has included information above that is not directly responsive to the particular issues raised by TDI but does not have other additional issues or considerations to bring up *at this time*. On behalf of TAHP and our members, we thank you for this opportunity and look forward to discussing the rules at the scheduled stakeholder meeting and having the opportunity to comment on any informal draft and proposed rules.

If you have any questions, please do not hesitate to contact me at [redacted] or [redacted]

Sincerely,

Jamie Dudensing

Jamie Dudensing

[4] The methodology used by NBER is a simple least absolute shrinkage and selection operator (Lasso) regression. This regression includes tuning parameters to various explanatory variables to minimize the effects of variance and bias. This would create an accurate estimation of emergency department costs in categories that can be applied in a representative fashion. In the very small number of emergency claims that may not be represented by the annual benchmarking database created by TDI but which are presented for arbitration we would recommend using H-CUP (Healthcare Cost Utilization Project) and NEDS (the Nationwide Emergency Department Sample) national benchmarks. These datasets are maintained by the Agency for Healthcare Research and Quality with funding from the National Institutes for Health, they are sources of information for use by researchers and are a clear presentation of factual information.

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CEO
Texas Association of Health Plans

cc: Melissa Eason
TAHP Regulatory Counsel