AARP Real Possibilities

CENTER for PUBLIC POLICY PRIORITIES

July 15, 2019

Texas Department of Insurance
333 Guadalupe Street
Austin, Texas 78701

Via: comments@tdi.texas.gov

RE: Informal comments related to rulemaking for Senate Bill 1264

To whom it may concern:

AARP Texas and the Center for Public Policy Priorities appreciate the opportunity to provide early input in the rulemaking process for Senate Bill 1264. As you know, we strongly support the bill and believe it provides long-needed and meaningful protections against surprise medical bills for patients with health plans overseen by the state.

In response to your request for written comments on issues identified by the Department, we offer the thoughts below.

Issue 1: Nonemergency exemption

A consumer may 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. What rules, if any, are needed to provide adequate consumer certainty and protection?

SB 1264 calls for a disclosure form, through which, a patient could waive their protections from balance billing when they *intentionally choose* to go out-of-network. Careful attention in rule is needed to ensure consumer protection in this area. Everyone agrees that patients should be able to make an informed *choice* to go out-of-network and agree to pay higher out-of-network prices, for example if they want to knowingly choose an out-of-network primary care physician, surgeon, or oncologist. However, SB 1264 is limited in scope to just health care scenarios where patients have *no choice* in their provider: emergencies, while at an in-patient facility, and labs/imaging services connected to an in-network physician. It is difficult to imagine many health care scenarios that both fall within the narrow scope of SB 1264 and would allow a patient to freely elect or decline out-of-network services without some level of duress. We should expect this waiver to be used infrequently.

Our initial thoughts are that rules should include:

- **Timelines.** The form must be given to a patient within 72 hours of the provider/provider's group being scheduled to perform a planned procedure, and the disclosure/wavier should only be valid if given at least 7 days in advance of the health care service. Said another way, for procedures scheduled far in advance, the patient asked to waive their rights should be told that there is an out-of-network issue relatively quickly after the provider could detect it that issue.

For procedures scheduled on short-notice, no waiver should be allowed if the patient does not have cost and option information at least 7 days out.

When a patient plans a procedure well in advance, they often have to make substantial efforts to get time off work, ensure their children are cared for, and otherwise prepare for the procedure and recovery. Even with a full week's notice that you'll either have to reschedule your procedure, identify alternate providers, or pay much more, a patient my feel that they have no real alternative other than to sign the form and pay more because they have already rearranged their work and family lives to accommodate the procedure.

- **Never while inpatient.** If a patient stays in a hospital for more than a week, it would be possible with only the timeline protection above for an out-of-network hospital-based provider to ask a patient to waive their balance billing protections for all services after seven days. Patients already admitted to the hospital should not be allowed to waive their rights even with a seven-day advance notice. There is simply no way to ensure that a hospital patient is electing out-of-network care free of duress.

- **Good faith estimate of *your* cost from the billing provider.** No patient should be allowed to waive their balance billing protection unless they first get a good faith estimate of their cost and agree to pay it to the billing provider. The cost estimate should be for the *specific* service or services the individual patient is expected to receive. It should be provided directly by the out-of-network billing provider who can generate a reasonable and individualized cost estimate, not through another parity like the facility or surgeon. Finally, if the actual balance bill exceeds the good faith cost-estimate, the waiver should be nullified, similar to the protection today at TIC 1467.051(d).

- **Language regarding options.** The waiver should make clear that the patient does not have to sign it and instead could work with his/her health plan or coordinating physician, if applicable, to identify alternate, in-network providers.

- **Consider notice needed for out-of-network post-stabilization care.** SB 1264 protects patients from surprise bills in emergencies and does not provide for a way for patients to waive those rights or "elect" out-of-network ER care. However, if that patient has been admitted to an out-of-network hospital through the ER and has stabilized, they are no longer protected. In this case, the patient will have to accept the financial liability of remaining in the out-of-network facility or transfer to an in-network facility. Patients in this position have to weigh complex insurance, financial, and medical tradeoffs when their health is compromised. They need clear and actionable information on costs and alternate in-network provider options, including options for in-network medical transport if needed. TDI should examine its ability to make standards for a similar type of disclosure at this transition.

Issue 3: Payment standards and hold harmless provisions

SB 1264 does not address nonemergency situations where a network provider is not reasonably available. 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?

First, we believe that where SB 1264 *does* fully protect consumers by banning balance billing and provides a dispute resolution system to arrive at reasonable payments, existing payment standards and hold harmless provisions are no longer needed to protect consumers. However, in other areas that SB 1264 does *not* address, such as with inadequate networks or when a network provider is not reasonably available in non-emergencies, TDI should require hold harmless provisions and access plan standards. We do not believe that a hold harmless standard should necessarily require a plan to pay whatever a provider demands, but it is an important consumer protection and clarification of the plan's obligation to fully protect its enrollee. TDI has a long history of actively engaging on balance billing issues to protect consumers. We recognize the value of maintaining the department's regulatory role through hold harmless and access plan standards, especially in circumstances where the legislature has not prohibited balance billing and consumer protection is needed.

Issue 5: Other considerations

Are there other issues or considerations that TDI should be aware of when drafting rules for SB 1264?

1. **In-network cost-sharing rate.** In a surprise billing situation covered by SB 1264, patients should never have to pay more in deductibles, copayments, and/or coinsurance than they would have had their care been in-network. Rules should clarify that patient liability is limited to in-network cost-sharing amounts and that amounts paid out-of-pocket accrue to in-network deductibles and out-of-pocket maximums (similar to protections/clarifications are found in 28 TAC 3.3725(d); 3.3708(b)(2) and (3); and 11.1611(d)).

2. **Facilitating transparent, collaborative, and robust enforcement across agencies.** We know that TDI will make every effort to enforce SB 1264 and protect Texas patients and consumers, but TDI simply cannot enforce SB 1264 alone. It will have to work closely with agencies that license providers and the Attorney General's Office. SB 1264's ban on balance billing is both an essential consumer protection and a big change for providers. We expect a steep learning curve and initial challenges with compliance. TDI will likely be the first state agency to hear about compliance issues around balance billing, but possibly not the best equipped to directly address them. We encourage TDI working with the AG's office and provider licensing agencies to enter into an MOU that spells out roles for each agency and how/when issues will be referred from one agency to another. We think that a transparent and formalized process will help state agencies and stakeholders better understand and work together to ensure consumer protection.

Thank you for consideration of these informal comments. We look forward to continuing to partner with the Department as it moves through rulemaking. Should you have any questions about our comments, please contact Stacey Pogue at [redacted] and Blake Hutson at [redacted]

Sincerely,

Stacey Pogue
Senior Policy Analyst
Center for Public Policy Priorities

Blake Hutson
Associate State Director
AARP Texas

AARP Real Possibilities

CENTER for PUBLIC POLICY PRIORITIES

August 9, 2019

Texas Department of Insurance
333 Guadalupe Street
Austin, Texas 78701

Via: comments@tdi.texas.gov

RE: Supplemental informal comments related to rulemaking for Senate Bill 1264

To whom it may concern:

AARP Texas and the Center for Public Policy Priorities appreciate the opportunity to provide additional input in the rulemaking process for Senate Bill 1264. As you know, we strongly support the bill and believe it provides long-needed and meaningful protections against surprise medical bills for patients with health plans overseen by the state.

In response to questions and comments that came up during TDI's stakeholder meeting on July 29, we offer our thoughts below on TDI's authority and the guardrails needed around the nonemergency patient waiver in SB 1264 to keep it from becoming a loophole.

TDI Has Authority to Write Rules that Protect Consumers

TDI has clear authority to write rules related to both the ban on balance billing and the exception to the ban (nonemergency patient waiver) from SB 1264, and should do so. TDI derives this authority from many sources.

- TIC § 31.002 provides broad authority for TDI to carry out provisions of the Insurance Code and protect consumers. Specifically, TDI is charged to "ensure that [the Insurance] code and other laws regarding insurance and insurance companies are executed," and "protect and ensure the fair treatment of consumers." Given TDI's consumer protection charge, TDI should exercise its authority in this section and the sections listed below to ensure that the exception to the balance billing ban doesn't swallow the rule, leading to consumer harm.
- TIC §752.0003(c) grants TDI authority to write rules to implement TIC Ch. 752, Enforcement of Balance Billing Prohibitions.
- TIC § 1467.003 grants TDI clear and broad authority to write rules to implement TIC Ch. 1467. In §1467.151(a), TDI is specifically charged with writing rules related to complaints arising from claims subject to TIC Ch 1467.
- In several matching provisions throughout Article I of the bill (Sec 1271.008(a)(3) is one example), TDI is specifically authorized to write rules about the content of the explanation of benefits (EOB) sent by the carrier to a provider to inform the provider of (1) the balance billing ban, (2) the amount the provider can charge for cost-sharing, and (3) about the availability of independent dispute resolution. This EOB is key; it is the catalyst for both the consumer protections in SB 1264 (the balance billing ban) and a provider's ability to seek additional

payment through dispute resolution. Any conditions required to make an nonemergency patient waiver of balance billing protections valid should be referenced in this communication.

Despite TDI's authority for rulemaking in these areas and its charge to protect consumers, primary enforcement of rules that govern provider behavior will have to happen in conjunction with or by agencies that license providers. We believe that health plans and TDI will be the most likely entities to be alerted to potential violations of SB 1264. We recognize that coordinating on enforcement will be a challenge. We urge TDI to write rules on the balance billing ban and the nonemergency patient waiver in a manner that protects consumers, and work with provider licensing agencies, ERS, TRS and OAG to devise a transparent plan for when complaints or issues will be referred between agencies for action or enforcement, what actions will follow, and each agency's specific role.

Strong Guardrails to Prevent a Loophole are Consistent with SB 1264

SB 1264's purpose is to close loopholes, not create them
Texas has had a system for surprise billing dispute resolution on the books for a decade, and for the entire time (until SB 1264 takes effect), the system was full of loopholes that kept many consumers with surprise bills from benefiting. Despite legislative tweaks to that system in 2015 and 2017, the limited reach of the law's consumer protections remained. SB 1264 is very different than the laws that preceded it. It's clear purpose is to close all of the loopholes that had frustrated consumers and legislators for years by creating ironclad consumer protection across all health plans the state can reach and all health care encounters that can lead to surprise bills.

The provision creating a nonemergency patient waiver needs to be interpreted within the context of the bill's intended purpose and consistent with the other provisions of the legislation. **The only way you can read the balance billing ban exception so that it is consistent with the rest of the bill is to read it narrowly – applying the exception only when a patient proactively chooses an out-of-network provider *over a readily available in-network one*, with full, advance information on financial implications and no delay in needed and/or scheduled care.** The only way the waiver can benefit consumers is if it allows a patient access to a specific provider that they have proactively chosen and who would otherwise not agree to treat the patient without the ability to balance bill.

We know some stakeholders have suggested loose or no guardrails on a provider's ability to use these waivers. There is no way to read a waiver that can be used broadly as consistent with the bill. There is simply no benefit to a consumer of a waiver that can be used by providers that are assigned to patients with no ability for the patient to select their provider, or when a patient has no readily available in-network alternative that allows scheduled and/or needed care to occur without delay or duress.

To be consistent with the rest of the bill and legislative deliberations of it, the waiver must be limited to instances when it would expand a patient's proactive choice of provider and not when it would merely expand a provider's choice of paths to seek additional compensation. The exception should not override the clear purpose of the bill – to protect patients and close loopholes, not create them.

Intent of the legislation
Based on the overall context for the bill, conversations we had with members and staff, and deliberations in committee and on the floor, we believe the intent behind the waiver is to allow a patient who knowingly and purposefully selects a specific out-of-network provider, despite having in-network alternatives, to agree to pay a specific amount that is more than would be due under SB 1264.

We do not recall any discussion or deliberation that envisioned broad discretion for providers to use waivers even when patients lack choice nor creating a mechanism where the consumer protections in SB 1264 could be bypassed.

Guardrails Needed to Effectively Implement SB 1264

Based on the discussion at the stakeholder meeting and our reflection on discussions we had during session on the waive provisions, we have refined our recommendation on the guardrails TDI should put in rule to implement the waiver in a manner consistent with the purpose of SB 1264.

Needed guardrails for the waiver include:

- **A precursor for use of a waiver must be the patient's proactive *election* of an out-of-network provider**. The statutory language limits application of the waiver to "a health care or medical service that the enrollee *elects* to receive…" (emphasis added). Patients cannot make an *election* to see an out-of-network provider when they had no choice in providers. Nor should they be considered to have *elect*ed an assigned out-of-network provider at a higher cost when they have no ability to choose an alternate in-network provider that will not delay needed and/or scheduled care or cause duress in decision making.

  On the waiver, the patient should attest to the fact that they knowingly selected the specific provider and that the provider was not assigned to them. They should also attest to having knowledge of alternative in-network provider options to receive timely care and that they rejected those alternatives.

  We believe that this guardrail is the most important for ensuring both consistency with the purpose of SB 1264 and consumer protection.

- **Waivers should not be allowed if they delay needed care or cause scheduled care to be rescheduled**. Sec. 1467.151(1) demonstrates that the legislature is concerned about delayed care for patients and wants agencies to prioritize complaints of delayed care even ahead of billing disputes. TDI has an opportunity now to limit patient complaints about delayed care through an appropriate guardrail. Providers should not be allowed to present a waiver to a patient if the creation of the price disclosure would delay needed and/or scheduled care. Also, provider should not be allowed to present a waiver if a patient's refusal to sign it would result in a delay to needed and/or scheduled care.

Others important guardrails to prevent the waiver from becoming a loophole include:

- **Timelines.** As we stated in our previous letter, we recommend a bookended timeframe. The waiver and disclosure must be given to a patient within 72 hours of the provider/provider's group being scheduled to perform a planned procedure, and the disclosure/wavier should only be valid if given at least 7 days in advance of the health care service. Said another way, for procedures scheduled far in advance, the patient asked to waive their rights should be told that there is an out-of-network issue relatively quickly after the provider could detect that issue. For procedures scheduled on short-notice, no waiver should be allowed if the patient does not have cost and option information at least 7 days out.

- **Never while inpatient.** Patients already admitted to the hospital should not be allowed to waive their rights even with a seven-day advance notice. There is simply no way to ensure that a hospital patient is electing out-of-network care free of duress.

- **Meaningful awareness**. Waivers and related disclosure should not be mixed in a stack of papers that patients fill out during in-take by a provider. Also, the provider or his/her representative should orally read the waiver to the patient in addition to providing it in writing. This is a best practice for facilitating consumer understanding of notices. There must be a high bar for awareness and understandability when a person is asked to waive their rights.

- **Good faith cost estimate of patient's actual responsibility.** The statutory language is clear: the disclosure that accompanies the waiver must provide "projected amounts for which the enrollee may be responsible." Patients should be given information for the *specific* service or services the provider expects to provide and the cost should reflect the patient's responsibility. Neither billed charges nor a formula for calculating charges is an estimate of the patient's responsibility. A patient's responsibility will depend on his/her plan design and the amount of the patient's deductible and out-of-pocket maximum already met. A provider will have to check in the with insurer to get this data. Carriers should be required to furnish this data when requested without delay. Patients should not be asked to waive consumer protections without a high standard set for meaningful and actionable information in the cost disclosure.

- **Waiver and disclosure provided for and by each billing provider.** The statute requires a separate waiver "with respect to each non-network physician or provider providing the service." The waiver and disclosure that accompanies it should be both generated by the specific, out-of-network provider chosen by the patient (so the projected services and patient's responsibility will be most accurate) and given to the patient by that provider or his/her representative, not through a third-party like a surgeon or facility (to limit consumer confusion and ensure a clear election).

Thank you for consideration of these informal comments. We look forward to continuing to partner with the Department as it moves through rulemaking. Should you have any questions about our comments, please contact Stacey Pogue at pogue@cppp.org and Blake Hutson at hutson@aarp.org.

Sincerely,

Stacey Pogue
Senior Policy Analyst
Center for Public Policy Priorities

Blake Hutson
Associate State Director
AARP Texas

July 15, 2019

American Surgical Professionals (ASP) is a Houston based company that employs surgical assistants who serve as first assistants in certain surgical procedures, primarily in hospital based settings.

A surgical assistant, also known as a first assistant, participates in surgery, acting as the second hands of the surgeon within the sterile field and with hands-on the patient. To be in compliance with Texas rule, surgical assistants can include a doctor, a physician assistant, a registered nurse, a Licensed Surgical Assistant, a registered nurse first assistant (who has received specialized training in first assisting), a person who is certified by not licensed as a surgical assistant or a person with none of these qualifications.

Historically, surgical assisting duties were performed by a co-surgeon or other medical doctor. However, as the cost and availability of medical doctors have made it prohibitive for them to continue to serve in this capacity, more and more over the years the surgical assistant role has been assumed by other trained medical personnel.

Most of the surgical assistants employed by ASP are Licensed Surgical Assistants, licensed under Chapter 206 of the Texas Occupations Code. In order to be eligible for such licensure, Licensed Surgical Assistants are required to have at least an associate's degree, to have passed an accredited surgical assistant program, including a required clinical component, to have obtained a national certification from a certifying body acceptable to the Texas Medical Board and to have passed a national exam acceptable to the Texas Medical Board in surgical assisting. Applicants must have also obtained 2,000 hours of operating room time under the direct supervision of a surgeon, and the surgeon or surgeons for whom they have worked must certify their proficiency to the Texas Medical Board. Lastly, License Surgical Assistants are required to regularly obtain continuing education credit and are subject to discipline by the Texas Medical Board.

ASP provides the following feedback (in blue) in response to the questions posed by the Texas Department of Insurance (TDI):

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? Surgical assistants generally do not have an opportunity to interact with the patient in advance of the procedure and therefore lack an effective means of providing a "complete written disclosure" in advance of the procedure. The rules should take this into account, preferably assigning the responsibility of

providing the disclosure regarding the surgical assistant's fee to either the facility or the surgeon, depending on which is responsible for assigning the assistant to work on the case.

- What specific information must the disclosure include to ensure consumers understand the potential out-of-pocket cost for the service? The information should include type of surgery to be performed and the surgeon's request that a surgical assistant participate in the procedure.
- What rules should TDI consider to prevent consumers from getting disclosures when they may be under duress? No response.

ASP question – SB 1264 provides that this exemption applies when the enrollee elects to undertake the procedure in writing following the disclosure. What constitutes "written election" by the enrollee?

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? No response.
- To what extent should the process provide each party with an opportunity to rebut the information another party submitted to an arbitrator? The information provided to the arbitrator by each party should be made available to the other party. However, the ability to rebut the material provided by the other party should not present a requirement for production of materials through a discovery process and/or an opportunity for delay of the proceedings longer than the 51 days afforded by SB 1264.
- Are rules needed to address how and when the parties must notify TDI if they cannot agree on an arbitrator? No response.
- Are rules needed to address fees and standards for arbitrators? Fees should be stated upfront and not subject to variation. The fees should be kept low so as not to deter arbitration requests.

ASP additional feedback – Surgical assistants do not have their own CPT codes; rather, the assistant bills using the same codes used by the surgeon along with a "modifier" to designate that the provider was acting as an assistant rather than as the surgeon. Because the surgical assistant does not know what percentage of the billed charge the insurer will pay for the assistant at surgery, in practice the surgical assistant bills for the CPT code as though acting in the capacity of a surgeon, and the insurance company in turn heavily discounts the billed charge and pays only a small percentage of the billed charge.

Without going into too much detail, this billing process has been inherited from CMS guidelines and procedures for reimbursement of surgical procedures. Under those procedures, CMS reimburses surgical assistants a certain percentage of what the lead surgeon receives as reimbursement, depending on the qualifications of the surgical assistant (i.e. whether they are another physician or another type of healthcare professional).

Given this practice and, given that the "amount in controversy" in a single arbitration cannot exceed $5000, it is important that the surgical assistant be permitted to bundle claims based on the amount that the surgical assistant is actually requesting as payment, rather than the original amount billed. One way of accomplishing this may be to allow the surgical assistant, in submitting the arbitration request, to define the "amount in controversy" as the amount that the surgical assistant is willing to accept for the procedure, rather than the original billed amount.

Note that, because SB 1264 does not apply to ERISA plans, and because surgical assistants are not permitted to maintain more than one chargemaster in a particular geographic area, surgical assistants cannot adjust these longstanding billing practices for one market without also compromising the billing practices in other markets that are not subject to the same rules. Utilization of the "amount in controversy" in the manner described above would solve this conundrum.

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?

ASP comment: Surgical assistants are generally out of network, either because insurers refuse to contract at all or refuse to contract at reasonable rates. ASP is unclear as to how TDI's rules for access plans apply to surgical assistant or are enforced by TDI.

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*."

ASP comment/question: How is it to be determined what is a "similarly qualified" out of network provider? Since, in Texas, the qualifications of a surgical assistant can vary greatly, insurers should not be permitted to determine what similarly qualified means. If insurers were to make this determination, this would likely skew the numbers submitted to the lowest possible reimbursement level.

Likewise, how will it be determined what is meant by the "same or similar specialty" in determining percentiles to be applied? Will this be interpreted as applying to the job title or the job actually being performed? ASP believes this should be interpreted as the job function and not based on the title, as all of the practitioners are performing the same clinical job function in the operating room. An interpretation applying job title would be considered discriminatory and would likely be a violation of the intent of ERISA and ACA.

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.

For ERS/TRS plans the usual and customary rate is as defined in the master benefit plan. Providers should have early, i.e. before surgery, and transparent access to the master benefit plans that apply. Currently, ASP does not have a method for obtaining such information as most commercial insurance companies are not willing to share this information.

SB 1264 requires the health benefit plan to provide notice to its enrollees that "a health care practitioner described by subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan unless the healthcare or medical service provided to the enrollee is subject to a law prohibiting balance billing." What definition of balance billing applies to these provisions? Additionally, can providers receive a copy of the health plan's notice to confirm it was provided and to see what the notice contains?

Finally, if a database is selected for benchmarking purposes, what data will be used for the beginning of the process, beginning January 1, 2020, if the rules regarding provision of the benchmarking data have not been in place for a sufficient period of time prior to January 1, 2020 to offer an adequate and reliable benchmarking standard?

America's Health Insurance Plans

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July 15, 2019

Kent Sullivan, Commissioner of Insurance
Texas Department of Insurance
333 Guadalupe
Austin, TX 78701

BY EMAIL – comments@tdi.texas.gov

RE: AHIP Comments for Stakeholder Meeting on S.B. 1264 Rule Development

Dear Commissioner Sullivan,

On behalf of America's Health Insurance Plans (AHIP), I am writing to provide input for the Department's (TDI) development of rules implementing the mediation and arbitration provisions of S.B. 1264 (2019), which addresses surprise medical bills. We appreciate this opportunity to share our national perspective in advance of the TDI's July 29th stakeholder meeting, as AHIP works across the states and with Congress to protect consumers from surprise medical bills.

AHIP and our members are committed to finding solutions to alleviate the financial burdens imposed on patients by surprise medical bills, which affect at least one in five Americans annually. The inflated prices put forth in surprise medical bills typically lead to health insurance providers and employers paying far more than negotiated rates for care, which increases premiums for everyone.

We offer the comments below on some of the issues identified in the stakeholder meeting notice.

Issue 1: Nonemergency Exemption and Provider Disclosure

AHIP applauds the legislature's efforts to ban balance billing in situations where patients are involuntarily treated by out-of-network (OON) providers and to hold patients harmless for costs other than in-network cost-sharing. Regarding consumer notifications, hospitals and other health care providers should be required to provide advance notice to patients about providers' network status, options for seeking care from a different provider, and costs of their treatment and options. Consumers should receive complete information about whether facilities or providers do not participate in their health plan and what that could mean for their financial obligations. This notice should be for informational purposes only and not constitute a waiver of patient rights or a release of obligations imposed upon facilities or providers. AHIP believes hospitals or other health care providers should be required to furnish patients with reasonably advance notice about the network status of treating providers when possible, but these notifications should never act as a loophole to balance bill patients for OON care.

Issue 2: Arbitration process

We understand that the Texas legislature has established an arbitration approach in S.B. 1264, and we look forward to working with the Commissioner on implementation of the new law. We recommend that TDI develop a balanced arbitration process that does not give undue weight to specialists' inflated billed charges and further encourage price gouging. Unlike their peers, these specialists charge 175-1200% of the rates that Medicare pays for the same services. Nothing about these inflated charges reflect the realities of the cost of care. If the newly enacted arbitration process favors inflated billed charges over negotiated, reasonable market rates, the final payment may likely represent an unreasonable amount. Placing guardrails around the opaque and costly arbitration process will be necessary to mitigate the likelihood that patients will see unnecessarily high costs as a result of this new bureaucratic system. AHIP also believes the new process should not be skewed by markets which are affected by disincentives to join networks.

In developing rules, we would further advise the Department to focus on minimizing costs, time expenditures, and administrative burdens. The demands of the process may lead to rewarding price gouging behavior and not adequately addressing the problem. In addition to outcomes based on billed charges that keep costs high, the price tag of simply disputing billed charges adds cost to the health care system.

AHIP's National Perspective

We would like to take this opportunity to also reaffirm AHIP's national position on solutions to the nationwide issue of surprise medical bills. To alleviate consumers' concerns about inflated, surprise medical bills, AHIP supports a benchmark approach which gives certainty to health plans and providers alike and should be designed to promote affordable care, reasonable reimbursement and market stability. Benchmarking rates to market-based negotiations and/or Medicare payment amounts will help address these high prices. Further, relying on such benchmark payment amounts would allow for local considerations and the costs of providing care by differing specialists to be part of the payment determination. Health plans negotiate different rates in different regions of the state based on unique cost considerations that underly the practice of medicine and provision of care in each area. Through these processes of good faith negotiations with health care providers, the factors that would otherwise be considered in an arbitration process are part of the negotiation. As Congress now debates reasonable reimbursement criteria, states across the country have taken various approaches to establishing an OON benchmark, including tying reimbursement to a percentage of Medicare or average contracted rates.

Several states, including Texas, have considered arbitration as an avenue to address surprise medical bills. While intended to protect consumers, assigning claims for OON reimbursement to

an arbitration process is not the best method for resolving surprise medical bills for consumers. It will still increase costs and not provide the necessary certainty for consumers. AHIP believes arbitration does not address the root cause of surprise medical bills – highly inflated prices from certain medical specialty providers who do not participate in networks because there is always a steady flow of patients coming through hospital doors.

Conclusion

Thank you for the opportunity to share our input and national perspective regarding surprise medical bills. Health insurance providers develop networks to negotiate better value and lower costs for the consumers they serve. When doctors, hospitals, or care specialists choose not to participate in health plans' provider networks, they charge whatever rates they like.

AHIP looks forward to the ongoing dialogue with the Department as it develops rules to implement the mediation and arbitration provisions of S.B. 1264. We continue to work towards solutions to alleviate the financial burdens imposed on consumers by surprise medical bills and to improve affordability of health care for Texans. If you have any questions, please do not hesitate to contact me at [redacted] or [redacted]

Sincerely,

Mara C. Osman

Mara Osman
Senior Regional Director

July 15, 2019

Via Email:
Kent Sullivan, Commissioner
Texas Department of Insurance
PO Box 149104
Austin, TX 78714-9104
comments@tdi.texas.gov

Re: SB 1264 Stakeholder Comments

Dear Commissioner Sullivan:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

Thank you for requesting stakeholder input on regulations that will implement Senate Bill 1264. We applaud the legislature for taking patients out of the middle of reimbursement disputes and creating a dispute resolution process for physicians and insurers. However, key provisions must be included by the Texas Department of Insurance (TDI) in implementing regulations in order to protect appropriate access to emergency care in Texas.

Definition of the Term "Relevant Allowable Amount"

Emergency departments in Texas are the healthcare safety net, providing care 24/7 to anyone who visits, no matter the ability to pay. We are concerned that insurers will limit their reimbursement for emergency care by unilaterally defining "relevant allowable amount." This is especially problematic for the majority of claims for emergency care when it is cost-prohibitive to use arbitration.

We urge you to specifically provide that the "relevant allowable amount" cannot be defined as a percentage of Medicare. Otherwise, access to emergency departments - which are Texans first line of defense when they face horrific accidents and debilitating medical conditions – will be in jeopardy.

According to the TDI's 2017 *Usual and Customary Survey*, 22% of insurers surveyed already exclusively reference Medicare rates for determining out-of-network reimbursement (TDI Report, Attachment 1). Our concern is that this percentage will drastically increase if regulations do not prohibit tying reimbursement to a percentage of Medicare. Medicare payments were never intended to reflect market rates. They were intended to reflect the federal budget. There is no reason the federal budget should impact reimbursement rates between two private parties: commercial insurers and physicians.

Emergency providers already provide more than their fair share of uncompensated and undercompensated care. Emergency physicians are 4% of physicians, yet they provide over two-thirds of uninsured care and over half of the care covered by Medicaid & CHIP. Moreover, because Texas has not expanded Medicaid, a greater percentage of patients visiting the emergency department are uninsured. So, emergency physicians in Texas are more dependent on adequate commercial reimbursement than in many other states. If commercial insurers also reimburse for emergency care at below cost, access to emergency departments in Texas will be in jeopardy. Commercial insurers must pay their fair share to protect access to the nation's healthcare safety net. Otherwise, patients may be required to travel longer distances and wait longer for emergency care.

In order to discourage insurers from manipulating data, we also urge you to tie any benchmarks to a transparent, unbiased, independent database, like FAIR Health. According to the TDI's 2017 *Usual and Customary Survey*, 70% of insurers referenced FAIR Health in determining reimbursements for out-of-network providers. In 2017, 2018, and 2019, Congress tried to improve the current greatest-of-three standard by directing the Administration to tie the standard to a transparent and unbiased charge database. EDPMA agrees with this approach. Other states like Alaska, Connecticut, and New York base emergency reimbursement on a database like FAIR Health. Additionally, the data in the FAIR Health database is robust and reflects fair reimbursement rates for a diverse Texas market. Such a standard is less easily manipulated, is transparent, and is enforceable. TDI recently announced using the database and EDPMA encourages TDI to implement rules that incorporate the use of FAIR Health for out-of-network emergency provider reimbursement.

Arbitration Process

The consensus is that NY-style arbitration has worked for all stakeholders: patients, insurers, and providers (see studies from the NY Department of Finance and Georgetown: https://nyshealthfoundation.org/wp-content/uploads/2019/02/new-yorks-efforts-to-reform-

surprise-medical-billing.pdf and https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9).

We urge you to adopt provisions similar to those implemented in New York. Specifically, New York's process is streamlined, efficient, and quick. Providers have a short period of time in which they electronically submit documentary evidence. Then, a few weeks later, the arbitrator decides which offer is more reasonable and payment is made.

In addition, in NY, there are provisions in place to ensure appropriate reimbursement for small emergency claims because it is cost-prohibitive to arbitrate most small claims. The cost of arbitration will most certainly be higher than the amount in dispute between the insurer and the provider. So, without a threshold payment for small claims, insurers would be able to easily skim savings off of each small claim without the worry of facing an arbitrator.

In NY that standard for small claims is the 80th percentile of charges. Payers and providers can easily look to a database and determine – with certainty – that the appropriate rate has been paid. Few emergency claims need to be arbitrated. In fact, in 2018, there were millions of visits to the emergency department in New York, only 849 emergency claims went to arbitration (NY State Department of Financial Services Data, Attachment 2).

Other Considerations

We urge you to adopt other important regulations that will improve transparency, protect patients, and ensure appropriate reimbursement for emergency care.

We encourage TDI to require insurers to disclose the type of plan (ERISA, Medicaid MCO, Medicare Managed Care, ACA plan, grandfathered plan, etc.), so the provider knows which set of patient protections apply to the claim. This could be done by imbedding the information into the plan number (such as a "-E" for ERISA plans). TDI should encourage the transparency of all insurance products sold in Texas, especially those involving patients.

In order to keep patient's out of the middle of payment disputes, there must be an automatic assignment of benefits. This also protects the healthcare safety net because physicians who are providing the care are more likely to receive the reimbursement for the care.

In order to address assignment of benefits, we encourage TDI to adopt the following language:

"Assignment of Benefits. -- There is an automatic assignment of benefits from the patient to the provider or group of providers. The provider or group of providers has the right to direct payment from the plan; the right to pursue administrative appeals or file suit for any cause of action; and the right to the same information, claim reviews, and other legal rights (including application of claims procedure regulations) as the patient."

We also support rules that continue to protect patients from paying a higher deductible when they inadvertently receive out-of-network care and further ensures that all cost-sharing

requirements count toward the out-of-pocket costs and the in-network deductible. This weakens the incentive to shift the cost of emergency care onto patients by narrowing networks and increasing the out-of-network deductible.

We also urge TDI to clarify the prudent layperson standard, a key patient protection in both federal and state law. Unfortunately, many insurers are violating this standard by automatically denying or down coding emergency claims when the ultimate diagnosis is on a list of minor diagnoses. CMS has already established that these policies violate the prudent layperson standard as follows:

a) **Relevant CMS Policy Stated in the 2016 Medicaid Rule:** The Medicaid Managed Care Rule finalized in 2016 reiterates *"we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. … The final determination of coverage* ***and payment*** *must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens."* (emphasis added to point out that both denials **and down coding** based on diagnosis is a violation of the federal prudent layperson standard).(*Key Page from Managed Medicaid Rule 2016*)

b) **CMS Reiterates Policy in 2018**: CMS Administrator Seema Verma sent a letter to EDPMA on March 15, 2018 reiterating that "*Whenever a payer (whether an MCO or a State) denies coverage* ***or modifies a claim for payment,*** *the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional).*
This State Medicaid Director letter is still in effect and can be found at:
http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html "
(emphasis added to point out that both denials **and down coding** based on diagnosis violates the federal prudent layperson standard). (*3/15/18 CMS Response Letter*)

c) **CMS letter in 2000 on standard: "***We strongly believe that, unless an MCO or a State has reason to believe that a provider is "up-coding" or engaging in activity violating program integrity, all claims coded as CPT 99283 through CPT 99285 are very likely to be appropriately regarded as emergency services for purposes of the BBA and should be approved for coverage regardless of prior authorization. This should not be taken to imply that claims coded as CPT 99281 and CPT 99282 will not also meet the BBA definition; they may, but, as opposed to those claims involving the higher CPT codes, there may be instances in which payers have a reasonable basis to disagree." (4/18/2000 Letter to State Medicaid Directors)*

We urge you to restate these important patient protection in Texas regulations as follows:

"Denying or modifying payment of Emergency/Clarifying Prudent Layperson Standard - - A plan may not deny or modify payment for emergency care unless an independent board-certified emergency physician has reviewed the medical record - including the patient's medical history and all symptoms - to determine if the level of care is appropriate. Reimbursement for care provided in the emergency department may not be reduced based on the final diagnosis. Plans must clearly inform patients that emergency care is covered, provide the patient with the legal definition of "emergency care," inform patients they are not required to self-diagnose, and inform patients that coverage for emergency care includes instances when there is a false alarm. Plans may not discourage appropriate use of the emergency department."

Thank you for considering our comments. Again, we urge you to (1) prevent insurers from unilaterally defining "relevant allowable amount" in a manner that jeopardizes the healthcare safety net, (2) base the arbitration process on the NY model which is proven successful, (3) prohibit insurers from implementing polices that violate the prudent layperson standard, and (4) encourage insurers to identify their plans. When implemented by the department, the Texas balance billing ban will truly protect patients from out-of-network billing and preserve patient access to emergency care by holding insurers accountable for addressing their own contributions to the state's healthcare safety net.

Please feel free to reach out with any questions.

Sincerely,

Bing Pao, MD, FACEP, Chair of the Board
Emergency Department Practice Management Association (EDPMA)

Senate Bill 1264 Rules Comments
Submitted on behalf of Facilities Management Group
2246 Bissonet Street
Houston, Texas 77005
July 15, 2019

We are pleased to submit comments related to the implementation of Senate Bill 1264, relating to consumer protections against certain medical and health care billing by certain out-of-network providers. Facilities Management Group encompasses six (6) emergency facilities located in and around Houston, Southeast Texas, and the Dallas/Forth Metroplex. We have reviewed the five issue areas identified by the Department and offer the following comments for consideration:

Issue 1: Nonemergency exemption

A consumer may 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?
- What specific information must the disclosure include to ensure consumers understand the potential out-of-pocket cost for the service?
- What rules should TDI consider to prevent consumers from getting disclosures when they may be under duress?

Discussion: Senate Bill 1264 exempts nonemergency health care or medical services from the balanced billing prohibition if an enrollee 1) elects to receive the service in writing in advance, 2) is provided a complete written disclosure that explains the physician or provider does not have a contract with the enrollees health benefit plan, discloses the projected amount for which the enrollee may be responsible, and discloses the circumstances under which the enrollee would be responsible for those amounts. SB1264 provides this exemption to state regulated PPO and HMO plans and state administered ERS and TRS plans.

While our standard practice is NOT to balance bill our patients, we would be concerned with any delay or interruption of the medical treatment required by rule. Rather than defining timelines for how much advance notice consumers must be given and potentially interrupting medical treatment, we would urge the Department to look for abuse retrospectively based on data collected on practices and complaints associated with nonemergency exemption and make referrals to the attorney general and/or appropriate licensure agencies as warranted.

We are also concerned the information elements required for the nonemergency exemption are not readily available to the provider and are only known by the health plan and consumer. For example, the "projected amounts which the enrollee may be responsible" is dependent in part on coinsurance or deductible cost share obligation. These amounts are generally not known by the provider, making an estimate by the provider of the out-of-pocket cost for the service difficult.

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?
- To what extent should the process provide each party with an opportunity to rebut the information another party submitted to an arbitrator?
- Are rules needed to address how and when the parties must notify TDI if they cannot agree on an arbitrator?
- Are rules needed to address fees and standards for arbitrators?

Discussion: As a facility, we are primarily concerned with the mediation process. We note that while SB1264 places a 51-day standard on arbitration, the legislation retained the 180-day rule for mediation. Regardless, we are concerned generally with the length of the dispute resolution process in general and urge the Department to incorporate procedures to expedite a fair resolution. The Department may, for example, want to consider requiring payment of any undisputed amount prior to the resolution, allow arbitrators to consider some penalty for a party responsible for delay, pre-qualifying a pool of arbitrators from which plans and providers choose, and/or adoption of rules of procedures for arbitrators.

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?

Discussion: Inadequate health plan networks provide the basis for balanced bills and a significant amount of consumer confusion. The Department should continue to increase its enforcement efforts for existing network adequacy standards. In addition, the Department should consider requiring more network transparency and more aggressively auditing to identify and correct deficiencies in a plan network.

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."

Discussion: Senate Bill 1264 requires the Commissioner to select an organization to maintain a benchmarking database and allows the Commissioner to adopt rules governing the submission of information for the database. With regard to definition of region referenced in Sec. 1467.083, in other sections of the bill, including 1467.006 providing for the benchmarking database, the “geozip area” is referenced as the geographic area for bill comparison. We would urge consistency between any definition of region and the “geozip area” called for in other sections of the bill.

In regard to the “submissions of information to the benchmarking database and how that information is used,” we would encourage the Department to consider adopting rules requiring plans to submit complete, accurate, and timely rate data to the benchmarking database. Whether the database is maintained by the government or private sector, we are concerned that the information maintained will continue to significantly trail the market. Current market data is a pre-requisite for Senate Bill 1264 and other legislation passed by the 86th Legislature to be effective.

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.

Discussion: Senate Bill 1264 removes the consumer from the possibility of a balanced bill in most circumstances. Under the current law, mediation may be requested only by an enrollee if there is a bill for emergency services in an amount greater than $500 for which the enrollee is responsible. Under Senate Bill 1264, a facility will now be able to directly request mediation for any amount billed by the provider and unpaid by a health plan for emergency care, out-of-network laboratory services, and out-of-network diagnostic imaging services. We anticipate provider mediation requests under the new law will also include instances where plans have denied coverage and payment and/or down coded the billed procedure. The Department may want to modify its data collection and reporting accordingly to account for these new elements.

We appreciate this opportunity to provide comments in advance of the stakeholder meeting on July 29th and look forward to attending and continuing to offer meaningful input into the Departments rulemaking process.

Submitted by Jonathan Abramson:

I have several suggestions and comments for TDI regarding the formulation of new rules to implement SB 1264.

Issue #1: Non Emergency Exemption

It is important that the written disclosure of out of network status and projected costs be provided enough time in advance of a procedure so that a patient will not feel they are under duress to sign. For example a disclosure provided at the time of admission would put a patient under a great deal of undue pressure to agree. Moreover patients should have a reasonable amount of time to consider the disclosure and act to request an in network alternative if they choose. The disclosure should also be provided to a patient within a reasonable amount of time after a patient requests to schedule a procedure.

For example a rule might say the disclosure, if a facility based provider wishes to issue one, must be provided within x business days of a patient requesting to schedule a procedure at a facility, but in no event less than x business days before the in facility procedure.

The patient should also agree to and sign the exemption for it to be valid.

All communications to providers about the new rules should make clear that at least the ancillary facility based providers over which patients normally have no choice in choosing, such as anesthesiologists, radiologists, and pathologists, are under no obligation to issue these non emergency exemption letters. All communications about the rules to providers should also note out of network facility based providers will receive payment for their services from the patient's insurance company through the arbitration process only if an exemption letter is **not** used and that having a patient sign one would shift responsibility for payment from the patient's insurance company to the patient directly in non emergency situations. Without such explicit clarification in communications about the rules to providers there could be a high risk of out of network facility based providers incorrectly believing they needed to send out exemption letters in order to be eligible to receive payment from a patient's insurance company.

Issue 3: Payment Standards and Hold Harmless Provisions:

Current Texas network adequacy rules don't work well for ancillary facility based providers, such as radiologists, anesthesiologists, and pathologists because they only say that a network must have an adequate number of providers for each specialty in a geographic metro area, not at each facility. An exemption letter given to a patient from an ancillary facility based provider warning that he or she is out of network will not allow the patient's quarterback/scheduling doctor to choose an in network alternative, and thus allow the patient to avoid balance billing, if there aren't enough in network facility based providers of the right type at that particular facility. Therefore new rules should say that networks should include a reasonable number of each type of facility based provider, such as anesthesiologists, radiologists, and pathology labs, at each in network facility.

If a non-emergency out of network exemption letter is sent to a patient by a facility based provider, the patient's insurance company should also be notified. The insurance company should then tell the patient and the 'quarterback/scheduling' doctor which facility based providers of that type are in network at that facility. If a minimum reasonable number of in network facility based providers of that type are not in network at the facility then the exemption letter should not be valid, the patient should be held harmless, and mandatory arbitration should take place. A letter to that effect should be sent to the patient and the doctor who sent the exemption letter.

Submitted by Lee Bukstein:

In the previous "out-of-network" billing dispute resolution scheme that has been administered by the State Office of Administrative Hearings (SOAH), SOAH created rules that were not mandated by the statute to exclude any potential mediator from participating in their program if that person also participating in any other way in providing legal services to patients, providers or facilities (anyone who might bill or be billed for health care services). This excluded me from being hired as a mediator, despite my complaints to SOAH that such a rule was not within their statutory grant of power.

Please do not propose rules that makes the same broad exclusion for the mediation and arbitration programs that are authorized by SB 1264. It is not necessary, because ordinary conflict of interest rules would prevent anyone with a real conflict from accepting such a job and the statute does not instruct TDI or any other licensing board to reject mediators due to the fact that a mediator has desirable experience and knowledge base about health care law and the health care industry.

SENATOR KELLY HANCOCK
CHAIRMAN

SENATOR ROBERT NICHOLS
VICE-CHAIRMAN

SENATE COMMITTEE ON BUSINESS AND COMMERCE

August 14, 2019

Commissioner Kent Sullivan
Texas Department of Insurance
Post Office Box 149104
Austin, Texas 78701

Dear Commissioner Sullivan,

For over a decade, I have worked to end the practice of surprise medical billing in Texas. This past legislative session, we passed a bill to completely protect consumers, and I look forward to TDI quickly implementing the legislation and giving Texans the relief they deserve.

We made sure that SB 1264 covered all scenarios where a consumer can receive a surprise medical bill for healthcare services from a physician they did not choose. These unfair and unexpected medical bills can occur in both emergency and non-emergency situations. During an emergency, it is impossible to plan ahead to ensure your care will all be in-network, but the same goes for ancillary health care providers associated with a planned medical procedure. *It is important that this key protection is not lost in rulemaking.*

Although the legislation does allow for consumers to waive their balance billing protections for non-emergency medical procedures, as was also allowed in the current mediation statute, this waiver is not intended to create a balance billing loophole. The non-emergency medical procedures exception is meant to narrowly allow for balance billing when a consumer actively chooses a health care provider and schedules a procedure in advance that they know to be out-of-network.

To implement the intent and wording of the law, rules should make clear:

- Any waiver must be given far in advance, to allow a meaningful opportunity for the patient to make an election to waive or not, and still get needed health care;
- Disclosures and waivers should not be buried in a stack of papers or otherwise presented in a manner that will still result in bills that surprise patients;
- The out-of-network provider must directly provide written disclosure to the patient; and
- The cost disclosure must include "projected amounts for which the enrollee *may be responsible*". A list of billed charges is not the same as the cost the enrollee may incur.

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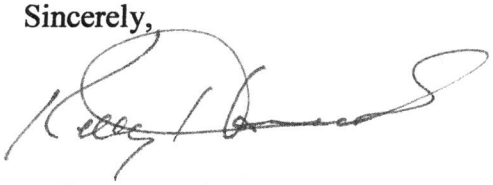
- Without a good faith estimate of the actual costs the patient will ultimately be responsible for, consumers will not have a meaningful opportunity to make an informed decision about waiving their rights.

The legislature spoke loudly and clearly across party lines and in both chambers this past legislative session that the time had come to end surprise medical bills. Throughout the discussions and drafting of SB 1264 there was complete agreement that consumers must be fully protected and taken out of the middle of billing disputes. Rulemaking on SB 1264 should not leave open loopholes that will continue to leave consumers with surprise medical bills when they have no meaningful choice of in-network providers.

Sincerely,



Kelly Hancock

July 12, 2019

MEMORIAL HERMANN

The Honorable Kent Sullivan
Commissioner
Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104

Re: Comments on Senate Bill 1264

Dear Commissioner Sullivan:

Memorial Hermann very much appreciates the opportunity to provide comments and feedback on rules to implement SB 1264 in advance of the July 29, 2019 public stakeholder meeting. Like many other hospitals across Texas, our System has already initiated and implemented several actions minimizing the occurrence of surprise bills impacting our patients resulting from the delivery of emergent health care services. We have been extremely active in our efforts to educate and ensure understanding of the relationships involved, operational considerations, and potential unintended consequences of contemplated decisions.

Attached you will find comments for your consideration. We request serious attention to the comments that we are providing and will make ourselves available for any required clarity or questions. We want to be a part of the solution – one that is long sustaining and not fraught with potential negative impacts resulting from concerns not brought forward and/or acknowledged in any due diligence process to establish the formal rules executing upon our State's recently passed legislation.

Thank you for your consideration and please feel free to reach out to any member of our team if you have any questions.

Respectfully yours,

Michelle Lindsley

Michelle Lindsley
VP, Managed Care

[redacted]

Freddy Warner
[redacted]

Ryan Ambrose
[redacted]

cc: Freddy Warner
Ryan Ambrose

SB1264 Comments / Feedback for TDI Review
Memorial Hermann

***SECTION 2.11. Section 1467.055, Insurance Code**, is amended by adding Subsections (c-1) and (k) and amending Subsections (g) and (i) to read as follows:*

*(i) A health care or medical service or supply provided by an out-of-network [a facility-based] provider [or emergency care provider] **may not be summarily disallowed**. This subsection does not require a health benefit plan issuer [an insurer] or administrator to pay for an uncovered service or supply.*

Will specific TAC rules and/or mandated penalties be adopted to ensure that insurers/HMOs don't:

1) "summarily disallow" or arbitrarily deny OON ER: "care or medical service or supply";

2) refuse to authorize some or all OON ER care, and then use "no authorization" as the reason for denying some or all OON ER care; and/or

3) improperly designate ER care and related services as non-emergency care, and then use "non-ER care from a non-network provider" as a pretext to deny some or all ER care and services?

Our below comments will also reference these concerns in more detail with additional context.

We would like to make sure valid amounts due to the provider under developed benefit designs are not unintentionally included in any balance billing prohibition. In addition, there is a fear a situation is created where a consumer potentially changes intermittent care patterns resulting from knowledge of no liability if services are sought in OON facilities.

Several sections (SB1264) outline what an OON provider may and "may not bill" an OON ER patient for as well as what an OON ER patient is and is not "financially responsible" for:

*(g) For emergency care subject to this section or a supply related to that care, **a non-network** physician or **provider** or a person asserting a claim as an agent or assignee of the physician or provider **may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's health care plan** that:*

(1) is based on:
*(A) **the amount initially determined payable** by the health maintenance organization; or*
*(B) if applicable, a modified amount as determined under the health maintenance organization's **internal appeal process**; and*

(2) is not based on any additional amount determined to be owed to the physician or provider under Chapter 1467.

1) What TAC rules will be adopted to ensure that SB 1264 will not diminish or cause an OON ER provider to relinquish any of their rights (as assignees) of their OON ER patient's health insurance policy, including but not limited to an OON ER provider's policy assigned right to be paid for all services and charges not covered or denied by the insurer/HMO?

2) What TAC rules will be adopted to ensure that SB 1264 will not diminish or cause an OON ER provider to surrender any of their rights included in the executed agreement between the OON provider and OON patient's assignment of benefits and related agreement(s)?

Additional Questions and/or Requests for TDI Clarification (through rulemaking process)

1) It has been TDI's position that the Texas Prompt Pay (TPP) law does *not* apply to fully insured claims on policies written or situsedin non-Texas states. Will TDI apply the same standard for the application of SB1264 (as TPP law and other TX INS CODE) and contend that SB1264 does not apply to claims for insurance policies written or situsedoutside of Texas? We would request consideration for alignment here.

2) What TAC rules will be adopted to prohibit an insurer/HMO from issuing a mandated payment pursuant to SB 1264 and/or TIC 1467, and then the insurer/HMO or one of the insurer's/HMO's affiliates or designated entities from later modifying all or part of the mandated payment (i.e. making a determination retrospectively a different amount should have been paid with initiated refund request to provider including threat of total or partial recoupment of original payment)? We request protection for providers through limitations on an insurer's/HMO's ability to retrospectively reduce such applicable payment.

3) Would like to ensure agreement specific to federal and state law reflecting an OON provider is not required to secure a pre-authorization or authorization for ER care in order to perform ER care and receive reimbursement for the OON ER care. We request assurance, possibly through TAC rule adoption, that insurers/HMOs shall not withhold mandated reimbursement for OON ER care because the OON provider did not obtain an authorization.

4) We request TAC rules be adopted to prohibit insurers/HMOs from denying some or all OON ER care instead of and/or refusing to issue reimbursement for OON ER care (i.e. retrospective reviews based on payor specific policies resulting in underpaid or denied claims).

5) There are penalties, fines and even injunctive relief included in SB 1264 for providers that fail to comply with aspects of the law. We request TAC rules to be adopted to impose comparable penalties, fines and injunctive relief against insurers/HMOs that fail to comply with SB 1264 (i.e. an insurer/HMO that shows a pattern of issuing either arbitrary coverage denials or very low reimbursements on OON ER claims). Accountabilities and responsibilities should be equally important under this legislation and one party not penalized to any greater degree over another resulting from unacceptable behaviors. In the absence of equality here, negative patterns can emerge creating unintended consequences and actual support of activities occurring not in the spirit of this legislation intent.

6) Since Texas & federal law adopted a "prudent layperson" standard for a patient or enrollee determining what constitutes ER care, we ask that the TDI rulemaking process clarify the extent to which emergency (ER) care begins and ends based on the patient's condition? We strongly request required consideration specific to continuity of care, patient safety concerns, length of stay (LOS) exclusions. Examples: a) Patient has emergent surgery, stabilizes, continuity of care required post stabilization; b) Patient has condition that warrants scrutiny regarding movement from ER admitted facility - should be an exemption here case by case; c) LOS partly patient safety...if expected 5 day LOS and insurer/HMO deems non-emergent after day 3, admin-resources-safety concerns for a two day or less stay movement here should cause consistent care concerns. ALSO, please keep in mind the facility CANNOT force a

patient to transfer once he/she is admitted. If patient refuses transfer, how does facility handle the balance bill for partial stay? Connects to nonemergency exemption.

7) The transferring of applicable patients from OON facilities to in-network facilities creates liability concerns. If an insurer/HMO fails or refuses to assist with coordination of a transfer of an OON ER (admitted) patient to one of the insurer's/HMO's in-network providers, can there be a TAC rule adopted to ensure that the OON provider is reimbursed at its usual and customary rate (per statute) until the insurer/HMO and OON provider safely and responsibly transfer the patient to an in-network provider? (i.e. current experience includes extreme challenges on the part of our system attempting to coordinate transfer with an insurer unsuccessfully - resulting in their available network of applicable providers' inability to accept the patient and our staff having spent exhaustive hours trying to support such a transfer. Please consider broader emergent care consideration of inpatient situations, initiated through an emergent condition, referenced in #6 above and this section #7 where payment under SB 1264 must extend the entire length of an inpatient stay vs denial from the insurer/HMO)

8) The TPP law (TIC 843.351 & TIC 1302.069) explicitly states the "the provisions of this subchapter relating to prompt payment by a HMO/insurer apply to a physician or provider who is not in the HMO/PPO network; and provides (to an OON patient/enrollee) care related to an emergency or its attendant episode of care". We request confirmation TDI will enforce the TPP law to ensure that OON Texas physicians and hospitals (that provider ER care) and the State of Texas are paid statutory restitution due from HMOs/insurers that improperly deny OON ER care claims and/or fail to comply with the statutory time requirements of the TPP law consistent with what we feel is the intent of referenced language.

9) In addition to applying to OON ER claims on fully insured health policies (governed by TIC 843 & 1301), Texas legislators mandated that SB1264 also applies to plans covered under TIC 1551 (TX State Employees), 1575 (TX Public School employees) & 1579 (TX School employees) plans. We request consideration for required identification, similar to the TDI reference on Fully Insured Plan ID cards, on the additional covered groups' ID cards so providers are able to comply with SB 1264 legislation. Operationally, providers must identify applicable patients and as services are accessed with the employer and captured at a school name level, there is additional information necessary to determine if the school, for example, falls to one of these included groups subject to this legislation.

10) This one an important question of clarity and response is necessary for provider and insurer/HMO expectations and prevention of significant mediation activity if unclear. Texas Administrative Code 3.3708 states, *"the insurer must pay the (OON ER) claim at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible"*. TX INS CODE compels HMOs/insurers to "fully reimburse" OON ER providers at their "usual and customary rates". If the charges on an OON ER claim are the provider's 'usual and customary rate', what specific circumstance would arise where the HMO/insurer would not have to reimburse the OON ER provider at the OON provider's billed charges/usual and customary rate? As a provider, we have an expectation for payment based on this referenced language and if there are thoughts on something different, we request broader conversations be initiated with stakeholders.

11) Since TDI ensures that all applicable policies/plans are processed in strict accordance with their policy contract, we ask that TDI adopt a TAC rule that prohibits insurers/HMOs from applying HMO/MCO network contracts to OON claims unless the policy/plan document OON benefits explicitly allow for OON reimbursement at a HMO/MCO contract or, in keeping with TX INS CODE, at the HMO or MCO contract if (and only if) an OON provider agrees to allow access to their HMO or MCO agreement for the OON ER patient".

12) Nonemergency Exemption/Disclosure. For OON non-emergency care, most facilities will not provide services without financial clearance obtained through a provided authorization and rate agreement prior to rendering services. The scenario here that can be challenging is the patient admitted through the ER, has a 5 day stay, but the insurer/HMO defines emergency care only for 2 days with 3 days now defined within one hospital stay as "non-emergency care". The facility more than likely won't be aware of the denial while the patient is in house OR if they are aware of the denial, will exhaust efforts to support continued medically necessary stay through discharge in the absence of the insurer/HMO initiating transfer discussions with the facility. Not realistic for the facility to track this activity and estimate projected costs before continued services. Admits and services initiated through the ER should be exempt from this specific disclosure requirement. For other services, facilities should be able to provide estimates as all are providing mostly today, if they so choose to provide services to applicable patients with authorization alone absent any other rate agreement. If there is a rate agreement, patient should be responsible for applicable liability per benefit design.

STATE of TEXAS
HOUSE of REPRESENTATIVES

Tom Oliverson, M.D.
District 130

August 9, 2019

Commissioner Kent Sullivan
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78701

RE: TDI rulemaking on SB 1264

Dear Commissioner Sullivan,

This past legislative session my colleagues and I joined together to tackle the pressing issue of surprise medical bills with comprehensive reforms aimed at ending the practice of balance billing when consumers have no reasonable opportunity to ensure they receive only in-network health care services.

Though our approaches to solving this dilemma for consumers varied at the outset, we consistently agreed that the goal of the bill was ironclad consumer protections. Throughout the legislative process, as we worked to build a fair system for resolving these disputes, at no time did the legislation ever waiver from its goal of ending surprise medical bills. Importantly, SB 1264 addresses surprise medical bills both in emergency care situations and non-emergency care situations when a patient did not actively seek out-of-network care.

Surprise medical bills can occur in both scenarios because patients are often unaware of all the various health care providers associated with their care even when a procedure has been scheduled in advance. Ancillary medical providers, who are at times out-of-network and almost always out of the control of the patient, may balance bill for charges beyond an insurer's reimbursement.

Our intention in this legislation was to create a *narrow* exception to the law's prohibition on balance billing aimed at situations where a consumer *actively and knowingly chooses* out-of-network care.

The waiver in SB 1264 is a limited exception. Specifically, the waiver is intended for non-emergency health care services that a patient "elects to receive in writing in advance of the service," and associated cost disclosure must provide "projected amounts for which the enrollee may be responsible." Additionally, there should a reasonable cooling off period between the time the waiver is signed and the time of the surgery/procedure.

This exception to the law's balance billing prohibition is not aimed at creating a loophole where patients may inadvertently waive their balance billing rights or do so under the stress of having to

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STATE of TEXAS
HOUSE of REPRESENTATIVES

Tom Oliverson, M.D.
District 130

choose to delay scheduled healthcare services. There should be absolutely no situation where a patient feels pressured to waive their rights under SB 1264. In addition, these waivers should apply only to elective care.

The clear intent and purpose of our bill is to protect Texas consumers and create a fair and balanced system for payors and providers, and we know you share that goal. We urge you to ensure that rules implementing SB 1264 do not inadvertently create loopholes where patients may continue to receive surprise out-of-network bills.

If you have any questions or concerns, please feel free to contact my office at 512-463-0661. Thank you in advance for your consideration.

Sincerely,

Representative Tom Oliverson, M.D.

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OFFICE OF PUBLIC INSURANCE COUNSEL
Melissa R. Hamilton, Public Counsel

OPIC Comments

The Office of Public Insurance Counsel (OPIC) thanks the Texas Department of Insurance (TDI) for providing the opportunity to comment on potential rules to implement Senate Bill 1264, 86th Texas Legislature. OPIC submits the following comments for consideration.

Issue

TDI identified the nonemergency exemption in Senate Bill 1264 as a key issue and has put forth for consideration whether rules are needed to provide adequate consumer certainty and protection. The nonemergency exemption 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.

To ensure that this disclosure is useful to consumers, it must be provided sufficiently in advance and in plain language so that the consumer can make an informed decision about whether to proceed with the out-of-network service.

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?

Senate Bill 1264 requires consumers to receive notice before a service is provided that may result in a balance bill. Senate Bill 1264 does not specify a timeframe or timelines for the notice. OPIC believes consumers would benefit from rules that give guidance on when the notice must be given to consumers.

Consumers should receive the notice with adequate time to analyze the costs and benefits of seeking medical care in or out of network. If the notice is not provided in a timely manner before the service, the inconvenience of finding another provider, scheduling another appointment, or taking more time off from work could deter consumers from canceling an appointment, even after becoming aware of the potential costs for seeing an out-of-network provider. OPIC suggests defining a time period or an event that would trigger when the consumer must receive the notice.

Are there other issues or considerations that TDI should be aware of when drafting rules related to SB 1264?

OPIC commends TDI's efforts to provide information in plain language that is easy to understand so consumers can make informed decisions about their health care. OPIC has also made plain language a priority for the agency. Accordingly, OPIC recommends that the

aforementioned notice is provided in a manner and format that consumers can easily understand.

Conclusion

OPIC appreciates the opportunity to provide comments in advance of the stakeholder meeting on potential rules for SB 1264 implementation. OPIC believes the advance notice requirement, which gives consumers notice of a potential balance bill, is an important consumer protection. This consumer protection could be even further improved upon with the development of rules to specify a timeline for the notice and a requirement that the notice be provided in plain language.

PCCOT
Patient Choice Coalition of Texas
807 Brazos St.
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Austin, TX 78701
tel: 832-877-0800

July 15, 2019

Via Email:
Kent Sullivan, Commissioner
Texas Department of Insurance
PO Box 149104
Austin, TX 78714-9104
comments@tdi.texas.gov

Dear Commissioner Sullivan:

The Patient Choice Coalition of Texas (PCCOT) is one of Texas' largest coalition of in- and out-of-network medical providers and facilities across all specialties who endeavor to deliver the greatest quality healthcare to Texans across this great state. With a membership consisting of 100's of providers including Ambulatory Surgical Centers, Freestanding Emergency Facilities, Physician-owned Hospitals, Infusion and Diagnostic Laboratories, Surgical Assistants, as well as more than 3,000 Individual Physicians, PCCOT represents a significant percentage of the providers delivering healthcare to patients across Texas. PCCOT works alongside our members to help facilitate their legislative involvement within all state agencies delegated for regulatory and/or consumer protection of health insurance related issues, practice management guidelines and most importantly, consumer protection.

PCCOT would like to acknowledge the challenging work and progress made this past session by all legislators and stakeholders to protect patients from Surprise Medical Bills and Surprise Insurance Denials. PCCOT believes strongly in dispute resolution utilizing existing and proven methodologies and practices ensuring both parties are adhering to current law and customary standards of practice, specifically within the realm of emergency medicine. In addition, thank you for your tireless efforts to improve healthcare transparency between providers and carriers while

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striving to remove and insulate patients from these transactions. The Patient Choice Coalition and its members are thankful for the opportunity to provide comments as well as participate in the stakeholder meeting for S.B. 1264. Ideally, rules surrounding the enactment of this legislation should strive to create an environment best suited for resolution without burdening the state, taxpayers, or the Texas Department of Insurance. With appropriate parameters and definitions, PCCOT believes dispute resolution will become the exception rather than the rule. However, without these key provisions or failing to clarify vague definitions surrounding Usual, Customary, and Reasonable, PCCOT is fearful the burden on the state will be overwhelming.

Rules Comments

ISSUE 2: ARBITRATION PROCESS:

ARTICLE 2. SECTION 2.01.

Comment: Given the vast difference in financial resources available to an insurer as opposed to a provider along with the cost in terms of both time and money, the provider is at a substantial disadvantage from the outset of the dispute resolution process. To make the dispute resolution process meaningful, as opposed to an expensive exercise in futility, the Department must ensure the rules being contemplated work to maintain a "level playing field" such that the financial strength of one party does not overwhelm the relatively weaker party thereby preventing the potential abuse or a "gaming" of the dispute resolution process and making an equitable settlement much more likely. Further, given the fact mediation is required before a party can institute litigation, the sheer number of disputes that will be processed through the system is likely to be substantial. Accordingly, in order to avoid the backlog of cases seen by the Department in previous mediation programs, the rules governing the dispute resolution process mandated by the Act must seek the maximize economy and efficiency to the greatest degree possible if it is to have any chance of being a manageable and meaningful process. To that end, the following general points are suggested for incorporation into the rules:

1. Whereas the arbitration provisions in the Act restrict the value of claims a provider may assert in a single arbitration proceeding, the provisions in the Act that provide for mandatory mediation do not restrict the number of claims or the value of those claims which may be asserted in a single mediation proceeding. As such, and in order to maintain a level playing field by means of making the process as cost efficient as possible for all

parties, and also enable the Department to manage the substantial number of mediation requests it is sure to receive, the rules should specifically state a provider subject to mandatory mediation under the Act may bring multiple claims without a limit as to the number of claims or value of those claims in a single mediation proceeding.

2. Given cost associated with internal appeal process coupled with the fact it rarely renders any meaningful change in an insurers position, the rules associated with mediation should seek to avoid delay and expense by permitting the provider to initiate the dispute resolution process without the need to go through the expensive a near universally futile internal appeal process, a process which qualitative evidence shows only serves to delay resolution of the ultimate issue. Accordingly, in order to further enhance efficiency and economy of the mediation process, the rules must prevent or otherwise discourage requirements which permit a party to delay settlement in an attempt to financially attrite (i.e., monetarily bleed the other party through delay) the other party.

The rules should permit a health benefit plan issuer or administrator and/or an out of network provider from, at any time either before or after initiation of the mediation process, negotiating and settling disputes outside of the mediation proceeding.

Further the rules should provide that in the event the parties voluntarily settle such dispute outside of the mediation process, the mutually agreed upon settlement will be entered in to the mediator's record.

The Rules should stipulate that requests for mediation through a portal on the Departments website should constitute notice to the other party so that disputes as to the receipt of notice are render moot.

Section. 1467.005(1). - A health benefit plan can easily refuse to offer a meaningful settlement until the provider has expended a substantial amount of time and incurred a financial obligation associated with the cost of the dispute resolution process. In order to prevent this abuse of the process, the Department should mandate that an issuer or administrator may offer a reformed claim settlement, provided no costs or financial obligations incident to the dispute resolution process has been incurred by the provider and, in the event costs and or financial obligations incident to the dispute resolution process has been incurred by the provider, the issuer shall be required to cover those expenses.

ISSUE 3: PAYMENT STANDARDS:

SECTION 1.07.
Subchapter A, Chapter 1301.010 Insurance Code:

Comment: In order to avoid ongoing consumer confusion regarding the application of the insured's benefits, the Department should require, that case of emergency care, the written notice mandated by the Act specify the insured's in-network benefits are being utilized as it relates to the

insured's contribution requirements i.e., the insured's copayments, coinsurance and deductible.

ISSUE 4: BENCHMARKING

Usual, Customary, and Reasonable
SECTION 1.08.
Section 1301.155(b), Insurance Code:

Comment: To ensure clarity and thereby lesson the burden on the Department and staff relative to provider underpayment complaints, the Department should specify that the term "usual and customary rate" as used in the Act relative to insurer reimbursement for the specified emergency care services must be compliant with the methodology required by 28 TAC §3.3708(c)(1) which requires insurers employ a methodology that is consistent with generally accepted industry standards and practices such that the result of the usual and customary analysis fairly and accurately reflects market rates, including geographic differences in costs.

Further, consistent with the Departments findings as reflected in its 2017 Usual and Customary Survey as amended, the Department should clarify in the rules now under consideration that Medicare based methodologies used by insurers to determine usual and customary payments to out of network providers that do not use a multiple sufficient to accurately reflect market rates as required by 28 TAC §3.3708(c)(1) do not meet the requirements of the Act.

SECTION 1.16.
Section 1579.002(8) Insurance Code:

Comment: In order to lessen the burden on the Department and staff, in those sections of that Act that define "usual and customary rate" as the "relevant allowable amount as described by the applicable master benefit plan document or policy", the Department require insurers to clearly explain how "relevant allowable amount" was determined or why the reimbursement amount constitutes the "relevant allowable amount".

Benchmark Data Base:
In order to determine what constitutes "usual and customary" payment to an out of network provider where that term is not defined in the Act as "relevant allowable amount as described by the applicable master benefit plan document or policy", a reliable market-based reference point for a particular service in a particular area must be established and maintained. To accomplish requirement of the Act, the rules must address the following issues:

Comment:
Source and accuracy of provider charge data: In order to maximize the accuracy of billed charge data reported to said independent benchmarking database employed to determine the required market based reference point, the Rule must require that all health benefit plans and administrators

provide to said independent benchmarking database, on a predetermined scheduled basis, all charge data submitted by out of network providers and certify the accuracy of such charge data so submitted in order to acquire or otherwise their maintain their ability to provide health insurance products in the State of Texas.

Rationale: This recommendation is made in direct response to testimony by health benefit plans and administrators relative to the fact they are no longer required by law to supply provider charge data to any independent benchmarking database, or to certify the accuracy of such data if provided.

Based on the foregoing, this recommendation is specifically designed to prevent health benefit plans and or administrators from frustrating the propose of the Act by either not submitting charge data to the chosen independent benchmarking database (thereby, over time, degrading the accuracy of said charge data due the insufficiency of the dataset), or otherwise providing the selected independent benchmarking database with inaccurate data designed to artificially skew the accuracy of the data in their favor and to the providers detriment, i.e., Ingenix 2.0)

Example of Success: New York's Independent Dispute Resolution Process works because of appropriate benchmarking is employed at the onset of determining the payment standard. New York Financial Services Law Article 6 Sec 603(i) Definitions – ""Usual and customary cost" means the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent." As a result, the "trigger" to enter IDR dissolves while the expections for both providers and carriers is established before IDR even begins. New York further elaborates as to the "reasonableness" of a charge by stating, charges are considered reasonable if they are below 120% of the 80th percentile. Anything above triggers their mediation process which we all know has become limited because of how well this legislation works.

ISSUE 5: OTHER CONSIDERATIONS:

Facility Clarification
SECTION 1.03.
Section 1271.155(b)(1), Insurance Code:

Comment: To ensure clarity, the Department should specify the term "comparable facility" as used in the in the Act includes a Freestanding Emergency Center ("FEC") Licensed under TAC 131;

Medical Records Provision
Section 1271.155(f)(1), Insurance Code:

Comment: In order to both lesson the burden on the Department and staff relative to provider prompt pay and related delayed payment complaints as well as to maximize the efficiency of this Section of the Act, the Department should specify in the Rules that the physician or provider may

submit to the health maintenance organization the subject patient's complete medical and billing records at the same time the physician or provider submits the subject electronic claim pursuant to Section 843.336 thereby ensuring the health maintenance organization has in its possession "all information necessary ... to pay the claim" within the required Thirty (30) day period without the need to request same. The Department's clarification of the foregoing will both simplify and drastically increase the efficiency of the billing and payment process by negating disputes and complaints regarding requests for additional information, the delay in payment as well as disputes related to the calculation of time periods associated therewith.

Additional Related Sections to same regarding medical records submission:

SECTION 1.06.
Section 1301.0053 (a) (1) Insurance Code:

SECTION 1.09.
Subchapter D, Chapter 1301(b)(1) Insurance Code:

SECTION 1.12.
Subchapter E, Chapter 1551(b)(1) Insurance Code:

Subchapter E, Chapter 1551.229(b)(1) Insurance Code.

SECTION 1.18.
Subchapter C, Chapter 1579(b)(1) Insurance Code:

Arbitrator's Determining Factors

SECTION: 1467.083

ISSUE TO BE ADDRESSED; the arbitrator's determination of the reasonable amount for health care or medical services or supplies provided to the enrollee by an out-of-network provider must take into account 10 items.

Comment: It would be helpful if the Commissioner would promulgate rules in regards to (4) the circumstances and complexity of the enrollee's particular case, including the time and **place of the provision of the service or supply**. In regard to item #4, non-traditional licensed emergency facilities vary in capabilities and it is of paramount importance to EMS transport that patients receive transportation to facilities that are capable of providing care at a level that is suitable to their emergency needs. EMS medical directors express concern if and when stopping at Freestanding Emergency Centers because there are varying levels of care offered at these non-traditional facilities. By utilizing GETAC (Governors EMS and Trauma Advisory Council) Destination Tool, arbitrators will be able to adequately determine what level of care those

Freestanding Emergency Centers offer to patients and whether those charges are considered reasonable in relation to acuity of care provided.

In recent years, Texas has experienced rapid growth of non-traditional licensed emergency care facilities. Freestanding Emergency Centers (FECs), Hospital Outpatient Departments (HOPDs), etc., have created new appropriate options for the transport of the EMS patient. State law assigns the responsibility for the destination of the EMS patient to the EMS Medical Director. In many RACs in Texas, EMS Medical Directors have collaborated to establish common destination criteria for trauma, stroke, and STEMI populations. EMS Medical Directors and RACs are faced with more and more options of evaluating these non- traditional licensed emergency facilities as a possible destination for EMS patients is both time-consuming and complex.

The Governors EMS and Trauma Advisory Council (GETAC) has developed this tool for EMS agencies and EMS Medical Directors to consider when evaluating non-traditional licensed emergency facilities for potential destinations for EMS patients.
This consensus document has been developed by an appointed task force with participation and input from industry experts and various public stakeholders in multiple meetings over a period of 18 months in 2015 and 2016. This document is primarily designed to be used in a situation when these non-traditional licensed emergency facilities co-exist in a typical transport area with general hospitals. GETAC recognizes there may be situations, especially in a rural market, when a non-traditional licensed emergency facility is the only reasonably licensed emergency center in the area. In this case, this tool can still be used by these rural EMS professionals to properly evaluate the capabilities of their facility (both traditional and non-traditional) with the understanding that the lowest capable facility may be the only destination option based on distance and other factors.

Thank you for your consideration of our comments and recommendations. The Patient Choice Coalition of Texas has worked with TDI for many years and greatly appreciates its efforts in providing protections to patients and their healthcare providers.

Please feel free to call or email if you have any questions or concerns.

Sincerely,

Dan Chepkauskas
Founder and Executive Director
Patient Choice Coalition of Texas
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In light of our limited time allotted as a stakeholder at the July 29, 2019 public meeting regarding Senate Bill 1264 (alternatively, "SB 1264" or, the "Act") and the potential rules (the "Rules") now being considered by the Texas Department of Insurance ("TDI"), we welcome the opportunity to offer this detailed supplement to those abbreviated comments, concerns and suggestions.

As discussed during the meeting, given both TDI's limited resources and the sheer number of claims that are certain to move through the system, the requirements of SB 1264 have the potential to saddle TDI and Staff with an unmanageable administrative burden unless, the rules now being considered:

1. make the entire billing, payment and dispute resolution process, each individual part of which is inextricably tied to the others, as efficient as possible, while;

2. simultaneously accomplishing the goal of consumer protection through;

    a. transparency, and

    b. to the greatest degree possible, by insulating patients from the inevitable disputes which occur between payors and providers.

It is our position that the only means of achieving the level of efficiency required to maintain a workable process while meeting the requirements of SB 1264 is for TDI to promulgate Rules which eliminates a party's ability to create inefficiencies in that process including, but not limited to those inefficiencies caused as a result of "gaming" the system. More specifically, Rules which prevent systemic inefficiencies designed to slow the billing, payment and dispute resolution process will in turn correspondingly reduce the number of incidents that result in complaints to TDI and will, thereby, represent the greatest opportunity to lower the administrative burden on TDI and Staff associated with the implementation and enforcement of SB 1264. In other words, it is our belief making this overall process the "exception rather than the rule" will ultimately result in the consumer benefitting in the end.

Specific Issues and Recommendations:

1. **SECTION 1.03**.
   Section 1271.155(b)(1):

   Issue: Clearly define the term "Comparable Facility"

   Comment: To ensure clarity, the Department should specify the term "comparable facility" as used in the in the Act includes a Freestanding Emergency Center ("FEC") Licensed under TAC 131;

2. **SECTION 1.03**.
   Insurance Code Section 1271.155(f)(1):

   Issue: Acceptance of medical and billing records at time provider initially submits claim

   Comment 1: While this comment specifically relates to Texas Insurance Code Section 1271.155(f)(1), to avoid repetition, we reassert the substance of this Comment in its entirety for each section of the Act which, in the case of care rendered in a licensed emergency department, requires an administrators and or health maintenance organizations to make payment directly to the non-network physician or provider not later than the 30th day after the date such administrator or the health maintenance organization receives an electronic clean claim as defined by Section 843.336 for the services in question that includes all information necessary for the health maintenance organization to pay the claim;

   Comment 2: In order to both lesson the burden on the Department and staff relative to provider prompt

pay and related delayed payment complaints as well as to maximize the efficiency of this Section of the Act, the Rules should specify the physician or provider may submit to the health maintenance organization the subject patient's complete medical and billing records (collectively "Additional Information") at the same time the physician or provider submits the subject electronic claim pursuant to Section 843.336 thereby ensuring, that for emergency care, the health maintenance organization has in its possession "all information necessary ... to pay the claim" within the required Thirty (30) day period mandated by SB 1264 without the need to request same.

Comment 3: The Department's clarifications of the foregoing will both:

1) simplify; and

2) drastically increase the efficiency of the billing and payment process by negating disputes and complaints directed to the Department regarding;

   - the timing of requests for additional information and specifically, those requests first made by administrators and or health maintenance organization after expiration of the Thirty (30) day period;

   - the delays in payment associated with a provider's alleged failure to submit requested medical records; and

   - the calculation of time periods associated with when a request for additional information is made and or when requested additional information is deemed received.

Comment 4: The following are just a few examples of the abuse of process caused by a "gaming" of the Department's current rules which the recommendations in this Comment are designed to stop and as a result, lesson the enforcement burden on Staff.

- Insurer waiting until the 29th day after claim submission to request Additional Information thereby delaying payment.
- Insurers requesting Additional Information for the first time after the initial 30 day period has elapsed.
- Insurer failing meet prompt pay deadline then submitting request for additional information for the first time in response to providers demand for payment. See Examples 1, 2, and 3 attached hereto.
- Insurer claiming to have never received requested additional information despite being provided with evidence to the contrary.
- Insurers requesting additional information more than one time.
- Insurers disputing when additional information was "received".
- Insurers delaying payment past the 30 day period based on requests for information from third parties, including the patient, their insured.

3. SECTION 1.07.
Subchapter A, Chapter 1301.010:

Issue: Prevent ongoing patient confusion relative to which plan benefit must be employed for care rendered in a licensed emergency room.

Comment 1: While this comment specifically relates to Texas Insurance Code Subchapter A, Chapter 1301.010, to avoid repetition, we reassert the substance of this comment in its entirety for each section of the Act which, in the case of care rendered in a licensed emergency department, mandates the disclosure of balance billing prohibitions and an explanation of benefits applied to the subject claim.

Comment 2: In order to avoid ongoing consumer confusion regarding the application of the insured's benefits, the Department should require, that in the case care rendered in a licensed emergency room, the written notices mandated by the Act specify the insured's in-network benefits are being utilized as it relates to the insured's contribution requirements i.e., the insured's copayments, coinsurance and deductible.

Comment 3: In our over 2,000 stakeholders' experience, patient outrage most often occurs when they receive an explanation of benefits from their insurance company and mistakenly believe it is a bill from their medical provider. While SB 1264's balance billing prohibition and the required notices associated therewith will temper some of that anger, another principle source of complaints to providers and the Department stem from an insureds confusion relative to which of their respective plan's benefits are being applied, i.e., in-network or out-of-network benefits. Despite the fact that, in the case of care rendered in an emergency room, both state and federal law requires insurance companies always apply an insured's in-network patient contribution benefits, Insurers routinely send patients and emergency room providers alike, EOBs which indicate out-of-network patient contribution benefits are being applied to the claim. The motivation for this misrepresentation is to circumvent state and federal laws that are specifically designed to protect patients when they are seeking emergency care. This is accomplished by deliberately misleading the insured so they believe if they seek care or later seek care in certain emergency rooms, they will pay more because their more expensive out-of-network benefits will be applied. In fact, even when emergency providers appeal an insurers initial decision to incorrectly apply an insured's out-of-network benefits, those appeals routinely fail to change the result. This deliberate attempt by carriers to make the insured "second-guess" a visit to one emergency department over another not only results in delays in treatment which may potentially lead to life-impacting negative health consequences, it also fails to take advantage of the state's available and licensed emergency departments deemed appropriate by statute as a facility fully licensed to deliver care to the population. Ultimately, this practice is only one of many profit protecting, "cost-containment" attempts by carriers to restrict access to care and direct patients, who are under "duress" as a result of their condition, to facilities where carriers unilaterally control costs.

The suggestion recommended in this Comment will substantially curtail if not out-right prevent this abuse of process by requiring insurers to unequivocally disclose to all of their insureds that when it comes to patient contribution requirements under their respective insurance plan, all emergency rooms are financially identical. Stated differently, mandating the suggested disclosure will prevent patient confusion and anger resulting from attempts to mislead through intentional misrepresentation and, in turn, accomplish the underlying goal of removing the patient from the inevitable disputes between payors and providers. More importantly, the foregoing will also reinforce the purpose of state and federal laws that are focused on patient safety by clearly explaining to insureds that they can go to any emergency room they wish without the fear of financial retribution from their insurance company by being responsible for larger copays and deductibles in one versus another.

4. SECTION 1.08.
Section 1301.155(b)

Issue: Ensure the methodology used to determine UCR meets the requirements of 28 TAC §3.3708(c)(1) relative to arriving accurate market rates.

Comment 1: To ensure clarity and thereby lesson the burden on the Department and staff relative to provider underpayment complaints, the Department should specify that the term "usual and customary rate" as used in the Act relative to insurer reimbursement for the specified emergency care services, must be compliant with the methodology required by 28 TAC §3.3708(c)(1) which requires insurers employ a methodology that is consistent with generally accepted industry standards and practices such that the result of the usual and customary analysis fairly and accurately reflects *market rates*, including geographic differences in costs.

Further, consistent with the Departments findings as reflected in its 2017 Usual and Customary Survey as amended, the Department should clarify in the rules now under consideration that Medicare based methodologies used by insurers to determine usual and customary payments to out of network providers that do not use a multiple sufficient to accurately reflect market rates (multiples which, based on TDI's 2017 Usual and Customary Survey as amended, can range from 9x to 12x Medicare rates) as required by 28 TAC §3.3708(c)(1) do not meet the requirements of the Act.

Comment 2: As in the past, underpayment to providers by employing methodologies that violate the requirements of 28 TAC §3.3708(c)(1) will likely be the source of most complaints to the Department and requests for dispute resolution. Accordingly, the current rule making process represents a unique opportunity for the Department to clarify mandated reimbursement requirements and thereby lower the burden on both the Department itself as well as on the dispute resolution process. Because of the sheer number of claims processed through the insurance reimbursement system coupled with the fact SB 1264 not only bifurcates disputes associated with a single patient encounter (i.e., arbitration for professional claims and mediation for facility claims), but also mandates the dispute resolution process itself, the Department's failure to avail itself of this opportunity to substantial limit the number of disputes/complaints due to underpayment represents a real threat to the viability of the entire dispute resolution process. In short, there simply will not be enough mediators available to manage the dispute resolution process pursuant to the requirements of SB 1264 should the Department chose not conclusively address this critical issue in a manner that forces compliance with 28 TAC §3.3708(c)(1).

5. SECTION 1.16.

Section 1579.002(8) Insurance Code:

Issue: Transparency as to how "relevant allowable amount" is determined.

Comment 1: In order to lessen the burden on the Department and staff, in those sections of that Act that define "usual and customary rate" as the "relevant allowable amount as described by the applicable master benefit plan document or policy", the Department should require insurers to clearly explain how "relevant allowable amount" was determined or why the reimbursement amount constitutes the "relevant allowable amount". Failure to require transparency on this issue not only sets the stage for increased number of complaints to the Department but also increasing the number of requests for mediation that could otherwise be avoided. Further, a lack of transparency associated with this issue also permits insurers and administrators to self-regulate which is not only dangerous but also is not contemplated by SB 1264.

6. ARTICLE 2. SECTION 2.01.

Issue: Maximizing the chances of the dispute resolution process routinely rendering equitable results through efficiency and by preventing abuse of process.

Comment 1: Given the vast difference in financial resources available to an insurer as opposed to an individual provider (physician and facility) coupled with the cost in terms of both time and money, the provider is at a substantial disadvantage from the outset of the dispute resolution process. To make the dispute resolution process meaningful, as opposed to an expensive exercise in futility, the Department must ensure the rules being contemplated work to maintain a "level playing field" such that the financial strength of one party does not overwhelm the relatively weaker party. Rules specifically designed to prevent the potential abuse or a "gaming" of the dispute resolution process itself will in turn result in a more effectiveness process that increases the likelihood of routinely arriving at equitable settlements. Further, given the fact mediation is required before a party can institute litigation, the sheer number of disputes that will be processed through the system is likely to be substantial. Accordingly, in order to avoid the backlog of cases seen by the Department in previous mediation programs, the rules governing the dispute resolution process mandated by the SB 1264 must

seek to maximize economy and efficiency to the greatest degree possible if it is to have any chance of being a manageable process that routinely results in equitable outcomes. To that end, the following general points are suggested for incorporation into the rules.

Comment 2. Whereas the arbitration provisions in the Act restrict the value of claims a provider may assert in a single arbitration proceeding, the provisions in SB 1264 that provide for mandatory mediation do not restrict the number of claims or the value of those claims which may be asserted in a single mediation proceeding. As such, and in order to maintain a level playing field by means of making the process as cost efficient as possible for all parties as well as enable the Department to manage the substantial number of mediation requests it is sure to receive, the rules should specifically state a provider subject to mandatory mediation under the Act may bring multiple claims against the same payor without a limit as to the number of claims or value of those claims in a single mediation proceeding.

Clarity on this issue is particularly important to maintain the viability of this aspect of the dispute resolution process because after mediation, the Act provides a party may seek redress in the courts. If the Department limits the number or value of claims a provider may submit to single mandatory mediation, providers will be forced to seek multiple mediations contemporaneously thereby straining what is sure to be an already severely taxed system. Further, assuming for a moment a certain percentage of those multiple contemporaneously mediated disputes do not result in settlement, the rules of judicial economy dictate that all of those claims between the same two parties submitted to the courts for resolution will be merged into one proceeding at trail. In short, limiting the number and value of claims that may be the subject of a single mediation between the same parties is not mandated by SB 1264 and further, would only serve to artificially increase the transactional cost to both parties, lesson the overall efficiency of the mandatory mediation process and threaten the viability of the process itself by increasing the number of mediation sessions that must be overseen by the Department and actually undertaken and completed by mediators and the parties while also potentially placing additional burden on the courts for failed dispute resolutions.

Comment 3. Given the cost and time associated with payors' internal appeal processes, coupled with the fact internal appeals submitted by providers rarely render any meaningful change in an insurers position, and further, due to the fact the requirements associated SB 1264's mandatory mediation do not dictate a provider must submit disputed claims through a payor's internal appeal process prior to seeking mediation, the Department's rules should similarly seek to avoid delay and expense by permitting the provider to initiate the dispute resolution process without the need to go through the expensive and near universally futile internal appeal process - a process which both quantitative and qualitative evidence shows only serves to delay resolution of the ultimate issue. Accordingly, in order to further enhance efficiency and economy of the Act's mandatory mediation process, the rules must prevent or otherwise discourage requirements which permit payors to delay settlement in an attempt to take advantage of a provider's weaker position by means of financially attrition (i.e., by monetarily "bleeding" the provider through delay).

Comment 4. The Rules should stipulate that providers and payors alike submit a single email address to the Department. Each submitted email would be accessible through the mediation portal on the Departments website and shall be used only to receive requests for mediation. Requests for mediation submitted via the portal to these dedicated email addresses shall constitute notice from one party to the other (i.e., akin to service of process to a registered agent). This will permit the Department to monitor the initiation of the mediation process so that disputes as to both the receipt of notice and the timing of such notice are rendered moot.

Comment 5. The rules should permit a health benefit plan issuer or administrator and/or an out of network provider to negotiate and settle disputes outside of the mediation process at any time either before or after initiation of such mediation process.

Comment 6. The rules should provide that in the event the parties voluntarily settle such dispute outside of the mediation process, the mutually agreed upon settlement will be entered in to the mediator's record so that if enforcement of that settlement is required, objective third party evidence exists as to what the settlement was as well as what each party's obligations are with respect there to.

Comment 7. Relative to Section. 1467.005(1), a health benefit plan can easily refuse to offer a meaningful settlement until the provider has expended a substantial amount of time and incurred a financial obligation associated with the cost of the dispute resolution process. In order to prevent this abuse of the process, the Department should mandate that an issuer or administrator may offer a reformed claim settlement, provided no costs or financial obligations incident to the dispute resolution process have been incurred by the provider and, in the event costs and or financial obligations incident to the dispute resolution process have in fact been incurred by the provider, the issuer shall be required to cover those expenses as a separate line item distinct from and in addition to the reformed claim reimbursement that is offered. This requirement will hasten offers of settlement, lesson utilization of the mediation process and prevent attempted avoidance of cost-reimbursement by "bundling" same with the reformed claim reimbursement being offered to settle.

Summary of Mediation Process Recommendations and Comments:

- Rules governing the mediation process must address the **vast difference in financial resources available to an insurer as opposed to a provider** and the fact the provider is at a substantial disadvantage from the outset of the dispute resolution process.

- The rules must seek **to maintain a "level playing field"** such that **the financial strength of one party does not overwhelm the relatively weaker party**.

- Given the fact the sheer **number of disputes that will be processed through the system is likely to be substantial**.

    - must seek the **maximize economy and efficiency** to the greatest degree possible

    - to **prevent the type of case backlog** seen by the Department in previous mediation programs,

    - To that end, the following general points are suggested for incorporation into the rules:

        - **Unlike the arbitration** process which the legislature has placed specific limits on in terms of numbers of claims and dispute value,

        - the **legislature did not restrict the number of claims or the value of those claims** a provider can seek to "settle" during **a single mediation** session.

        - As such the department should promulgate rules that reflect the intent of the legislation by:

            - **permitting a provider to seek to settle whatever claims it may have with a specific insurer in one mediation session** thereby maximizing the efficiency and economy of the system to the greatest degree possible.

        - Given **cost and futility of the current internal appeal process**; and

        - The fact exhausting an insurers **internal appeal process <u>is not mandated</u> by the SB 1264,** and

- Attempting to exhaust the current internal appeal process will **only delay** and increase the cost of getting to **a resolution of the ultimate issue**;

- The rules governing mediation should permit the provider seek mediation directly.

- In order to prevent a gaming of the system, the Rules should stipulate that both **providers and insurers alike provide and email address through the portal the Department is required to maintain**, **to receive requests for mediation and other notices** much like a registered agent does for companies.

    - This will **prevent disputes as to the actual timing and the receipt of notices** by parties and thereby lower the burden on the department.

7. **<u>Benchmark Data Base</u>**:

Issue: In order to determine what constitutes "usual and customary" payment to an out of network provider where that term is not defined in the Act as "relevant allowable amount as described by the applicable master benefit plan document or policy", a reliable market based reference point for a particular service in a particular area must be established and maintained so that the methodology used to arrive at UCR meets the requirements of 28 TAC §3.3708(c)(1) which requires insurers' employ an approach that is consistent with generally accepted industry standards and practices such that the result of the usual and customary analysis <u>fairly</u> and <u>accurately reflects *market rates*</u>, including geographic differences in costs. To accomplish this requirement of the Act, the rules must address the following issues:

Comment 1: <u>Source and accuracy of provider charge data</u>: In order to maximize the accuracy of billed charge data reported to said independent benchmarking database employed to determine the required market-based reference point, the Rule must:

1. require that all issuers, payors, health benefit plans, administrators provide to said independent benchmarking database;

2. on a predetermined scheduled basis;

3. all charge data submitted by out of network providers; and

4. certify the accuracy of such charge data so submitted;

5. in order to either initially acquire or otherwise maintain their ability to provide health insurance products in the State of Texas.

Rationale: This recommendation is made in direct response to testimony by issuers, payors, health benefit plans and administrators relative to the fact they are no longer required by law to supply provider charge data to any independent benchmarking database, or to certify the accuracy of such data if provided.

Based on the foregoing, this recommendation is specifically designed to prevent issuers, payors, health benefit plans and administrators from frustrating the propose of the Act by either not submitting charge data to the chosen independent benchmarking database (thereby, over time, degrading the accuracy of said charge data due the insufficiency of the dataset), or otherwise providing the selected independent benchmarking database with inaccurate data designed to artificially skew the accuracy of the data in their favor and to the providers detriment, i.e., Ingenix 2.0)

8. Considerations as to the location of care provided: GETAC FSED Matrix

Issue: In order to further clarify considerations referenced in Article 2., Section 2.05 and 2.15, Subchapter 1467.083 to be used in the dispute resolution process as it pertains to the location of care, specific to disputes resulting from care received in freestanding emergency departments (FSEDs) governed by both 25 TAC §131 and 25 TAC §133, adoption of the Governor's EMS and Trauma Advisory Council's (GETAC) developed standardized method for Texas EMS district Medical Directors to objectively evaluate the clinical capabilities of a FSED for the purposes of determining the facilities ability to receive and appropriately treat emergency 911 dispatched and transported patients to FSEDs from the community would serve to improve the dispute resolution process and further public and Department transparency. Of mention, GETAC's FSED matrix, further published on the Texas Department of State Health Services (DSHS) website for public consumption and distribution, was designed to alleviate the burden to the state, and ultimately the consumer, by reducing the requirements for additional tax resource allocation to EMS districts resulting from population growth and increased demands on resources by incorporating licensed FSEDs under both 25 TAC §131 and 25 TAC §133 in the emergency medical system. Factors influencing delivery of this category of emergency patients to FSED facilities was to be determined by the clinical capabilities and available staffing specific to the individual facility rather than the facilities insurance network status. This matrix served to "level" FSEDs based on a myriad of factors and classified each facility, regardless of ownership status, as a facility highly capable of accepting 911 traffic (Level 1), a moderately capable facility (Level 2), or a low capability facility (Level 3). Resultingly, EMS district Medical Directors, upon visiting and verifying the facility's capabilities and adherence to GETAC's standards, would allow the FSED facility to receive emergency 911 traffic.

Comment: An additional reduction of access effort example made by insurers is to confuse or otherwise dis-incentivize patients from seeking care at FSEDs. See attached Example 4 illustrating the deliberate effort on behalf of carrier to isolate FSEDs by charging higher co-pays for care rendered in these facilities.

Rationale: Adopting GETAC's model would serve to provide additional justification for the dispute resolution process when determining the appropriateness of the location providing care as well as provide increased transparency to both the Department and consumers.

GETAC Matrix:

	Category I	Category II	Category III
Category Definition:	Highest Capabilities; consider appropriate EMS patients	Intermediate Capabilities; consider low acuity EMS patients	Lowest Capabilities: Routine EMS transport not recommended
Staffing - Physician	24/7 board certified (ABEM or AOBEM) in emergency medicine	24/7 board certified (ABEM or AOBEM) in emergency medicine	24/7 licensed physician
On Call Phys / Surge Capability	24/7 published on call	24/7 published on call	No
*If there are PAs or APPs on staff need, must have 2 yrs experience in emergency med or board certification as emergency APP	May be the on-call/surge staffing	May be the on-call/surge staffing	N/A
Staffing - Nursing	24/7 Two RN's, ACLS, PALS, and TNCC or ATCN	24/7 One RN with at least ACLS and PALS	24/7 One RN with at least ACLS and PALS
On Call Nursing / Surge Capability	24/7 published on call	24/7 published on call	No
Radiology capability Ct, US, xray	On site 24/7	On site 24/7	Access to
Additional Staffing	24/7 minimum paramedic level training ACLS and PALS	24/7 minimum paramedic level training ACLS and PALS	No
Staffing - radiology tech (includes CT Tech)	On site 24/7	On site 24/7	On Call
US Tech	On call	On call	On call
Staffing - other	Registrar / clerk 24/7	Registrar / clerk 24/7	No
Medical Director	BC/BE in emergency medicine	BC/BE in emergency medicine	BC/BE in emergency medicine or primary care
Sedation / analgesia capabilities	Deep	Moderate	No
Stroke - tpa	Capable	NO	NO
Stroke - neuro on call or N-tele	24/7	NO	NO
Stroke - transfer agreement	YES	NO	NO

Stroke - EMS agreement	YES	NO	NO
STEMI - card on call	24/7	NO	NO
STEMI - fibrinolytics	YES	NO	NO
STEMI - transfer agreement	YES	NO	NO
STEMI - EMS agreement	YES	NO	NO
Trauma - transfer agreement	YES	NO	NO
Trauma - EMS agreement	YES	NO	NO
Landing Zone Capabilities	Agreement or capability to use air ambulance	NO	NO
EMS Transfer agreements	YES	YES	YES
Active participation in RAC as defined by RAC Bylaws or SOPs	YES	YES	YES
Disaster participation	YES	YES	YES
Performance Improvement & Data submission requirements	YES	YES	YES
Ventilator	YES	YES	No
Difficult airway kit	YES	YES	No
12-Lead capability	YES	YES	YES
Video laryngoscopy	YES	YES	No
Communication with EMS: telephone/radio with established number for EMS	YES	YES	No

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July 15, 2019

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104

Via email to: comments@tdi.texas.gov

Re: Comments regarding the implementation of Senate Bill 1264

Dear Opinion Committee:

Our firm represents the Texas Association of Freestanding Emergency Centers (TAFEC), which is Texas' freestanding emergency centers association. The association works with state leaders to ensure the fair regulation and growth of this industry, as well as raising public awareness of the industry and promoting an overall understanding of the unique benefits of freestanding emergency centers. TAFEC exists, in part, to raise statewide awareness of freestanding emergency centers as a high-quality, accessible, emergency medical care option. To that end, TAFEC appreciates the opportunity to file these comments regarding the Department's upcoming rulemaking and stakeholder meetings related to the implementation of Senate Bill 1264.

TAFEC fully supports the Legislature's action to remove patients from reimbursement disputes, and TAFEC is fully invested in helping create a dispute resolution process that works effectively for emergency facilities and insurers. To that end, TAFEC believes that some of the dispute resolution processes must be defined in order to assure the mediation process encourages the resolution of all explicit and implicit disagreements.

For example, the scope of the revised mediation process, including questions of coverage, and disagreements regarding downcoding and levels of care, remain an underlying cause of slow-pay and no-pay complaints by providers to the Department. While the explicit purpose of dispute resolution is "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," a necessary prerequisite to reaching a consensus on the appropriate amount of payment is to first reach an agreement on what services were appropriate to provide to the patient. Assuring the ability to mediate a "$0 payment" by the plan, and the ability to have the parties review and discuss the patient's medical record, are important. Likewise, TAFEC members are interested in assuring that the mediation process retains a strong emphasis on the prudent layperson standard.

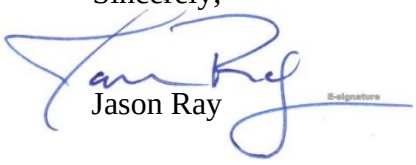
TAFEC in interested in hearing how the new mediation system dovetails with the current complaint process. Expediting or expanding the dispute resolution process may

supplement and compliment TDI's complaint resolution process. Hopefully, a strong dispute resolution system can reduce the need to invoke the complaint process at TDI.

TAFEC joins similarly situated emergency care providers and facilities in their concerns related to: 1) properly benchmarking appropriate reimbursement rates, 2) preventing any party in a payment dispute from unilaterally defining "relevant allowable amount" for reimbursement, 3) bracketing mediation timelines and processes to assure that the 180-day period does not become a tactic to delay payment, 4) rules that would allow the facilities to bundle mediation claims, 5) rules that would permit facts in an arbitrated dispute (regarding payment to a physician) to be considered in the subsequent mediation of the payment dispute regarding the facility that served the same patient on the same date of service, and 6) having the Department modify its data collection and reporting accordingly to account for these new elements.

On behalf of TAFEC and its members, we appreciate the opportunity to provide these comments. We look forward to attending the stakeholder meeting and continuing to offer meaningful input into the Department's rulemaking process.

Sincerely,



Jason Ray

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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?**

TAHP Response:

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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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August 19, 2019

RE: **Rulemaking Re: Senate Bill 1264 Rules**
Supplemental Comments

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 hosting the recent stakeholder meeting regarding its rulemaking to implement Senate Bill 1264. We offer the following additional comments in response to other stakeholder comments:

The Texas Association of Health Plans supported SB 1264 because it creates some of the strongest patient protections in the nation from outrageously expensive surprise medical bills that are currently bankrupting Texans. However, we are still concerned about the potential for unintended consequences and would like to reiterate the importance for a thoughtful and deliberative rule making process that avoids any further negative impacts to the market and/ or Texas patients

Texas has the most expensive emergency care prices and the highest rates of surprise billing the country. The primary goal of the rule making should be to implement strong patient protections while not further exacerbating the health care cost crisis in Texas and while staying within the bounds of the legislation. Additional rule making that addresses network adequacy, provider directories, utilization review, the statutory "prudent layperson" standard for emergencies, or other issues not addressed by SB 1264 is not authorized by the bill.

Non-Emergency/Elective Exception to Balance Billing Prohibition

It is critical to keep in mind that the prohibition on surprise balance bills is the default standard established by the Legislature in the bill. Out-of-network providers are not *required* to give the disclosures and cost projections before providing a service. SB 1264 gives providers who may not (otherwise) balance bill opportunities to dispute health plan payment amounts. It allows providers to balance bill enrollees only in the limited situation where an enrollee has been given the information needed for an informed decision *and has actively chosen ("elected")* to see a

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specific out-of-network provider. TDI rules must ensure that patients have sufficient time to make a decision, which will not be the case if they are given the information while they are inpatient in a hospital or immediately prior to a scheduled service. The purpose of the disclosures is to avoid "surprise" balance bills, so the disclosures must be specific enough that the enrollee will not be surprised by the amount that he or she owes to the out-of-network provider. In various situations where an out-of-network provider is not able to give complete disclosures with appropriate advance notice, the exception is simply not available and the "default" requirements of SB 1264 apply to that provider and to the enrollee's health plan.

It is important to note that the exception created by the disclosures and an enrollee's election (in subsection (d) of the new statutes) is an exception to each full statutory section that includes both the prohibition against balance billing (subsection (c)) and the requirement to pay the claims at the "usual and customary rate or at an agreed rate" (subsection (b)). The health plan's claim payment obligations under these subsection (b) provisions in SB 1264 do not apply to claims for services that an enrollee has elected to receive (in writing in advance) following receipt of an out-of-network provider's "complete written disclosure" pursuant to subsection (d). The rules should therefore require providers to identify any such services (to which subsection (d) applies) *upon claim submission* so that the health plan knows which out-of-network payment standard applies and whether arbitration or mediation may be available.

Arbitration Process

The process must be fair and unbiased, and stay within the bounds of the new statutes. SB 1264 (in new section 1467.083) is very clear that the only issue for arbitration is the reasonable amount of payment for a service. An arbitrator has no role in determining if or how services are covered under the enrollee's specific benefit plan, including whether or not services fall within benefits for emergency care.

The bill is also very clear regarding arbitrator qualifications and conflict of interest standards. TDI must give preference to knowledge and experience in contract and insurance law and the health care industry generally. Prohibited arbitrator conflicts of interest include current or recent ownership or employment by any health care provider. Therefore, health care providers may not be arbitrators or involved in making the arbitration decision.

TAHP disputes that SB 1264 was "modeled on" New York state law. While a few (but not all) of the provisions regarding factors to be considered in arbitration appear to be based on the New York law, many provisions of the New York law were obviously not included in SB 1264 and many provisions of SB 1264 clearly have no relation at all to New York law. Thus, the Department has no authority to base its rules implementing SB 1264 on provisions of New York law that were not adopted in Texas.

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No New Benefit Mandates:

As described in our initial written comments, TAHP recommends that the rules clarify that SB 1264 does not create any new mandated benefits (other than supplies related to covered emergency services) and that the disclosures accurately reflect an enrollee's potential responsibility for full billed charges for non-covered services. The disclosure should ensure that patient is fully aware that if the service is not a covered benefit, they will be responsible for the entire bill.

Benchmarking Database - TAHP recommends that TDI expand as necessary the de-identified claims reporting 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 for the state than contracting with an external entity that may or may not have data adequately representing market rates. It also will be more accurate than any commercial database.

Any process for using a commercial database should include a public review and RFI/RFPs that will allow consideration of the validity of each database. Any database used must be transparent about the sources of the data included.

We also recommend that the data be collected and considered in arbitrations separately for the different types of benefit plans: Marketplace Individual, non-marketplace Individual, Small Group and Large Group, separately for HMO, EPO and PPO claims. Claim data for self-funded ERISA plans should not be included.

On behalf of TAHP and our members, we thank you for this opportunity 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 jdudensing@tahp.org or 512-476-2091.

Sincerely,

Jamie Dudensing

Jamie Dudensing
CEO
Texas Association of Health Plans

cc: Melissa Eason
TAHP Regulatory Counsel

Texas Hospital Association

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July 15, 2019

Via electronic submission to: comments@tdi.texas.gov

The Honorable Kent Sullivan
Commissioner
Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714

PUBLIC COMMENT LETTER

Re: Texas Department of Insurance Rules Implementing Senate Bill 1264

Dear Commissioner Sullivan:

On behalf of our more than 450 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the Texas Department of Insurance's forthcoming rules implementing Senate Bill 1264, 86th Legislature. SB 1264 prohibits balance billing of patients for out-of-network emergency care and, for facilities, establishes mediation as a mechanism for resolving disputes with payers.

THA remains supportive of protecting patients from unexpected medical expenses and believes that eliminating patients' financial responsibility beyond known, required cost-sharing amounts for out-of-network emergency or unplanned health care services is fair and reasonable. It is essential that TDI's rules do not disrupt existing networks, interfere with private contracts or unfairly advantage health plans. THA respectfully offers the following comments.

Issue 1: Nonemergency Exemption

SB 1264 exempts certain nonemergency health care or medical services if a facility provides a written disclosure of projected amounts for which the patient may be responsible and the circumstances under which the patient would be responsible for those amounts. THA requests that TDI require payers to explain how they will calculate their out-of-network allowable payment. Without this requirement, the hospital cannot accurately calculate the patient's expected co-insurance obligation or the non-covered/denied amount. In addition, THA requests that TDI include provisions to require payers to increase member education on network participation and how to identify in- and out- of-network providers.

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. THA believes the nonemergency exemption should not apply when a patient is admitted to another level of care through the emergency department of a hospital and all or a portion of the care is denied by the payer. The facility will more than likely be unaware of the payer's determination that all or a portion of the patient's visit is deemed

nonemergent. Even if the facility became aware of the payer's determination, it would not be appropriate for the patient to sign a disclosure. The facility will treat and discharge the patient with the proper level of care that the patient's clinical team deems medically necessary.

THA ask that TDI not adopt a specific timeline for advance notice given to consumers before receiving a service that may result in a balance bill. An excessive notice period could result in unnecessary delays in nonemergent care. The timeline should be dictated by the facility's receipt of all pertinent information to provide sufficient information to the patient.

Ideally, TDI would develop model language for a disclosure statement so that hospitals and other providers could easily implement the requirements. The disclosure should include the estimated amount the payer will allow for the service, which must come from the benefit plan. The notice should include:

- A clear reminder that this service has been deemed non-emergent and the facility is not an in-network provider under the patient's benefit plan.
- The estimated total charges for the visit/service.
- The allowed amount determined by the benefit plan.
- The anticipated denial by the benefit plan (calculated as the difference between the expected charges and the payer's allowed amount shown as the patient's responsibility on the notice).
- The deductible or copay reported by the patient's benefit plan (deducted from the allowed amount).
- The expected co-insurance reported by the patient's benefit plan (also deducted from the allowed amount).
- A reminder that the patient may contact the benefit plan to dispute the anticipated allowed amount.

THA requests additional information from TDI regarding the circumstances involving preventing consumers from receiving disclosures when under duress. Although well-intentioned, a duress exemption could result in uncertainty and unwarranted litigation. To avoid uncertainty, patients should sign a disclosure that states: "I understand that my condition has been deemed non-emergent and that this hospital is not an in-network provider under my benefit plan. I have chosen not to leave (or reschedule) this service at an in-network provider and I understand that my financial responsibility will be larger because of my decision to receive services at this facility."

Issue 2: Arbitration Process

Under SB 1264, arbitration of out-of-network bills does not apply to hospitals and other facilities. However, Texas hospitals have an interest in ensuring a fair and efficient dispute resolution process for physicians and providers working in their facilities. Parties should be given adequate time to settle the dispute before moving to arbitration. If parties attempt to resolve a dispute and it is not resolved within 90 days, arbitration could be considered for an individual or group of claims. For an arbitration process to work effectively, both parties should be granted an opportunity to argue their positions with the provider being able to support its billing practice based on resources required to provide the service, or other relevant information. THA believes TDI should not settle disputes or set arbitrator fees. Market-based fees may encourage parties to settle outside of arbitration.

Issue 3: Payment Standards and Hold Harmless Provisions

A situation where an out-of-network encounter is due to a payer's failure to maintain an adequate provider network differs from one where a patient incurs an unexpected out-of-network medical bill in an emergency situation. THA recommends that TDI's payment standard for nonemergency situations where a network provider is not reasonably available include a guarantee of prompt payment for the encounter at a rate that fully compensates the provider and incentivizes the payer to expand its network to accommodate its members. If an out-of-network encounter is due to a payer's failure to provide its members with an adequate network, the payment standard should be more than the usual and customary rate to incentivize the payer to comply with Texas' network adequacy laws and regulations.

Issue 4: Benchmarking

THA looks forward to participating in the discussion regarding the benchmarking database that applies to the non-facility provider claims subject to arbitration. A benchmarking database is not necessary for claims subject to mediation because facilities generally have a well-established usual and customary rate with payers.

In addition to focusing on payment-related metrics, THA asks that TDI devote resources to addressing network adequacy, for example, by identifying which metrics indicate the frequency of gaps in a payer's network. A benchmark metric could be developed, for example, for how often a payer uses an access plan to address gaps in its contracted network.

Issue 5: Other Considerations

SB 1264 and current TDI rules do not adequately address situations where a payer summarily disallows, denies (in whole or in part) or classifies as nonemergent a claim for emergency care. A payer's determination that a service does not qualify as emergency care could skirt the spirit of the new law. THA asks that TDI subject claims to the rules governed by SB 1264 based on whether the claim submitted by the provider or facility originates from a claim for emergency care, rather than based on the payer's later determination of a nonemergency. THA also asks that TDI's rules prevent payers from requiring prior authorization for emergency care, which both delays lifesaving treatment and serves a basis to deny payment to a provider. Similarly, THA recommends that TDI adopt more stringent regulations for retrospective reviews.

SB 1264 includes fines, penalties and injunctive relief for providers and facilities that fail to adhere to the new law. THA asks that TDI develop comparable fines, penalties and injunctive relief for payers that exhibit a pattern of unwarranted coverage denials or underpayment. Payers and providers should be equally accountable for improper or illegal practices.

Although there is a 90-day window to request arbitration, there is no timeline to request mediation. For consistency, THA suggests including a 90-day deadline to request mediation.

TDI requires plan identification cards subject to TDI's regulations to include the letters "TDI". SB 1264 applies to additional plans covered under chapters 1551, 1575 and 1579, Texas Insurance Code. THA suggests that TDI require a similar plan identification card designation for these plans.

Because there are penalties for non-participation in mediation, THA requests that TDI develop a rule that confirms the facility receives actual notice from TDI. Facilities should be allowed to designate an individual or specific office for notice, much like a company that designates a registered agent for service of process. In addition, THA asks that TDI make clear that an in-network hospital is not required to participate in arbitration for a claim submitted by an out-of-network physician working at the facility.

Respectfully submitted,

D. Cameron Duncan III
Associate General Counsel
Texas Hospital Association

July 15, 2019

VIA ELECTRONIC MAIL to comments@tdi.texas.gov

Comments
Texas Department of Insurance
Austin, Texas

Re: Stakeholder meeting on Senate Bill 1264 rules

Dear Sir or Madam,

The Texas Medical Association, Texas College of Emergency Physicians, Texas Society of Plastic Surgeons, Texas Radiological Society, American College of Obstetricians and Gynecologists District XI, Texas Society of Anesthesiologists, Texas Orthopaedic Association, Texas Society of Pathologists, and Emergency Department Practice Management Association (collectively referred to herein as the "Associations") appreciate this opportunity to comment on the Texas Department of Insurance's ("TDI" or "the Department") notice of issues for discussion in the stakeholder meeting on Senate Bill 1264 proposed rules, as distributed via email on June 28, 2019.

As TDI is aware, the Associations have a keen interest in issues relating to health insurance coverage, network adequacy, and medical billing. Over the years, the Associations have advocated for strong consumer protections directed at addressing the root causes of "surprise billing," namely, inadequate health plan networks and inaccurate directories maintained by health plans.

Accordingly, we appreciate the opportunity to offer our input on the issues identified by TDI relevant to the implementation of Texas' most recent surprise billing legislation (Senate Bill 1264). In this letter, we summarize some of our initial comments on potential TDI rules for Senate Bill 1264. However, given the short comment period for this letter and the critical nature of the issues addressed in the letter (to both Texas' patients and physicians), we would appreciate the opportunity to supplement the letter after the upcoming TDI stakeholder meeting. The comments in this letter are not intended to be all-inclusive, and we anticipate the need for additional comment on the issues addressed in this letter, as well as on numerous other issues that are likely to be identified after submission of this letter.

I. Issue 1: Nonemergency exemption

In issue 1 in TDI's stakeholder notice, the Department references provisions of Senate Bill 1264 that provide exceptions to the health plan payment requirements and balance billing prohibitions of the bill. Those exceptions apply in certain nonemergency circumstances under which the provider gives the consumer "a complete written disclosure" that includes projected costs before providing the service. Specifically, the language in the bill states:

> (-) This section does not apply to a nonemergency health care or medical service:
> (1) that an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and
> (2) for which a non-network physician or provider, *before providing the service*, provides a complete written disclosure to the enrollee that:
> (A) explains that the physician or provider does not have a contract with the enrollee's health benefit plan;
> (B) discloses projected amounts for which the enrollee may be responsible; and
> (C) discloses the circumstances under which the enrollee would be responsible for those amounts. (emphasis added).

TDI asks what rules, if any, are needed to provide adequate consumer certainty and protection with regard to the above-referenced provision of the law. And, more specifically, TDI poses three questions, which we address below.

A. 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?

With regard to the first question, the Associations note that the bill itself, Senate Bill 1264, directly addresses the required timing of the advance notice exception by stating that the notice must be made "before providing the service." Thus, under the plain language of the statute, no particular amount of advance notice or waiting period is required in order for the notice to be effective (as long as it occurs in advance of the service). To impose a particular timeframe through rulemaking could have unintended consequence on patient care.

We, therefore, generally support the plain language of the statute in terms of timing of the notice. We believe that the plain language of the timing provision provides flexibility while addressing the core issue at hand (i.e., removing the "surprise" from an unanticipated balance bill by

conveying the required information necessary to put the patient on notice of the financial implications of the service prior to the provision of the services).

With that being said, we certainly are interested in working with TDI to ensure that the requirements of the law are implemented effectively and in a consumer-friendly manner. Thus, we are interested in hearing other perspectives concerning any potential need for any additional advance notice beyond that set forth in statute. However, at the same time, we caution the Department to carefully consider the potential negative consequences of imposing an inflexible specific timeframe for advance notice, as requiring a specific amount of advance notice (even a short minimum notice period) may impede or delay care and/or limit consumer freedom of choice. Moving forward, the Associations will be consulting with the specialties represented in their membership to address how to protect patients in these situation while not impeding the ability for patients to seek treatment in a timely and efficient manner.

Given the wide variety of services covered by Senate Bill 1264 and the varying circumstances for providing and scheduling those services, any proposed one-size-fits-all timeframe for the notice would be difficult to craft and may present new challenges to patients and physicians alike. It could also result in required waiting periods even for the most informed patients who urgently need or desire more timely and/or convenient care.

For example, if TDI requires a specific amount of advance notice, then patients may have difficulty scheduling procedures, particularly same day procedures, procedures in urgent care scenarios, and procedures in circumstances where the insured intentionally selects an out-of-network provider (e.g., due to the provider's experience and reputation) with full knowledge of the potential for increased out-of-pocket costs. Such a potentially arbitrary or artificial timeframe could hinder patient choice, delay care and deter an insured from using his or her out-of-network benefit.

Additionally, requiring a specific amount of advance notice without accounting for changes in circumstances (e.g., scheduling cancellations resulting in earlier appointment openings or scheduling one service and then discovering the need for another service during that surgery) may impede the efficient delivery and receipt of care.

The Associations note that Texas' informed consent statute for requiring disclosure of possible risks and hazards related to medical care and surgical procedures (i.e., Texas Civil Practices & Remedies Code Section 74.101 et seq.) uses similar flexible notice language. It simply requires advance notice of risks and hazards "[b]efore a patient… gives consent to any medical care or surgical procedure." The Texas Medical Disclosure Panel has honored the statutory language and not imposed specific timeframes through its rulemaking process. So, patients may sign an advance notice form disclosing potential risks and hazards a short time before the procedure is initiated on the same day of the procedure. This allows for flexibility in the timing of those notices so that practices can incorporate the notices in a manner that promotes the most efficient and effective delivery of health care. A similar allowance for flexibility in timing should be applied with regard to the out-of-network election disclosure form under Senate Bill 1264.

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

Two of the prongs of the out-of-network election disclosure form in SB 1264 are: (1) required disclosure of projected amounts for which the enrollee may be responsible; and (2) required disclosure of the circumstances under which the enrollee would be responsible for those amounts.

In order to satisfy the first prong referenced above, TDI rules should not require physicians to disclose any information on projected costs other than an estimate of billed charges, to the extent such an estimate is possible and services are predicted/scheduled in advance. Consistent with the Legislature's requirements for an estimate under Sec. 101.352(c) Occupations Code (i.e., SB 1731), the estimate must be of billed charges because any other information relevant to the patient's out-of-pocket costs (i.e., coverage information, deductibles, copayments, and coinsurance are within the health plan's control and are not readily available to physicians prior to the provision of services).

Additionally the second prong, referenced above, should be satisfied by inclusion of language similar to the estimate disclosures in Sec.101.352(c), Occupations Code, which would inform consumers that: (1) the actual charges for the services or supplies will vary based on the patient's medical condition and other factors associated with performance of the services; (2) the actual charges for the services or supplies may differ from the amount to be paid by the patient or the patient's third-party payor; and (3) the patient may be personally liable for payment for the services or supplies.

In order to facilitate more uniform disclosure of the out-of-network service election form under SB 1264 and provide more certainty to patients, physicians, and health plans, TDI may want to consider developing a form (with input from the Texas Medical Board) that physicians subject to the bill may use to meet the statutory disclosure elements for the exception. Physicians and health care providers should not be required to use the TDI form in order to utilize the exception (if the physician or health care provider's disclosure otherwise complies with the elements of the law that should also be sufficient).

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

The Associations note that TDI asks what rules it should consider to prevent consumers from getting disclosures when they may be under duress. It is unclear to the Associations precisely what circumstances TDI is contemplating in this question; and we have concerns with the use of the term "duress" in this context. We note that, as previously mentioned, for informed consent for the care or procedure itself under Civil Practices and Remedies Code Section 74.101 et seq., the Legislature did not see a need to include statutory language mandating a particular notice period in the law in order to avoid potential claims of duress. The same is true in the out-of-network election disclosure form.

Senate Bill 1264 itself contains limiting language to prevent a patient from being provided an out-of-network election form in an emergency scenario (which would be the scenario that would come closest to reducing patient choice to sign the form or not, because in an emergency situation, care cannot be delayed to seek another physician or provider). In nonemergency

scenarios (which is when the out-of-network election disclosure form may be valid under the law), a patient is not under the same pressures as an emergency situation, and the patient can seek care with a different physician or provider (although with some patient inconvenience if the patient does not wish to sign the form).

We are open to suggestions to the extent that such suggestions are workable for patients and physicians or to the extent, if any, that there is a specific demonstrated form of abuse. However, we are concerned that some stakeholders may inappropriately equate the inconvenience of rescheduling a service or the general stress associated with illness, the need for medical care, or the expense of medical care with duress. Further, if a form were truly signed under "duress" as that term is construed under Texas law, then the patient already has recourse as the patient may assert duress as a defense to the enforceability of the contract.

II. Issue 2: Arbitration Process

Next, the Department notes that SB 1264 requires the arbitrator to provide the parties with a written decision not later than the 51st day after arbitration is requested (unless the parties agree to an extension). TDI, then specifically asks what rules, if any are need to ensure procedural fairness and meet the strict deadlines set by SB 1264. More specifically, TDI asks the following three questions:

A. Are there existing arbitration processes or models that should be considered?

When considering arbitration processes or models, we would recommend that the Department consider New York's independent dispute resolution process for surprise bills (to the extent described herein). As the Department is aware, the Texas law was modeled, in part, after the New York law and includes certain elements verbatim from the New York law (such as certain factors to be considered in determining the reasonable fee for a service or supply). In its stakeholder meeting notice, the Department expressed concern that the Texas law's arbitration process must be completed within the strict deadline of 51 days. We note that the New York IDR process must be completed within a short timeframe as well. Thus, we are hopeful that reviewing some of the New York approach and determining the extent to which some of the processes in New York are workable under the Senate Bill 1264 framework will help in developing the process in Texas.

We also note that although the Texas law (Senate Bill 1264) uses the word "arbitration" and the New York law's process is informally described in newspaper articles as "baseball style arbitration," the processes set forth in SB 1264 and New York law do not mandate use of traditional arbitration processes and should be much more streamlined than a traditional arbitration process. In fact, there is language in the bill that expressly exempts the surprise billing dispute "arbitration" process developed under SB1264 from Texas' law on arbitration found in Title 7 of the Civil Practices & Remedies Code. Thus, by the plain language of the bill, the Texas Legislature expressed an intent for the independent dispute resolution process in SB 1264 to be a more efficient and less costly process than traditional arbitration.

It is the Associations' understanding that in New York, the Department of Financial Services works with independent dispute resolution entities (rather than just independent arbitrators) to

resolve its surprise billing disputes. In setting up the process in that manner, there may be efficiencies related to the volume of surprise billing IDR reviews/economies of scale. TDI should explore similar methods to reduce arbitration costs in Texas.

The Associations have heard anecdotally that some have estimated that the potential cost of Texas' arbitration process as being as high as $5000. These estimates seem grossly inflated and unreasonable, given: (1) the limited factors that may be considered under the language of the bill; and (2) Texas' process under SB 1264 differing from traditional arbitration processes. If arbitration fees/costs are exorbitant, the process will become cost prohibitive and of reduced availability, which is counter to the intent of the Legislature. It is imperative that the maximum fee/costs for arbitration be lower than the bundling claim cap in order to keep the arbitration process open to claim disputes over smaller amounts in controversy as well as to small practice groups with limited resources. Moreover, access to the arbitration process, in general, (regardless of the amount of the claim) is imperative because the process was included in the bill to promote some level of fairness in out-of-network claims payment matters.

In New York, it is our understanding that the typical fees for its surprise billing IDR process have been as follows:[1]

	IMEDECS	IPRO	MCMC
Full Review	$ 325.00	$ 225.00	$ 300.00
Negotiation/Settlement	$ 250.00	$ 150.00	$ 175.00
Application Processing/ Rejection as ineligible	$ 150.00	$ 95.00	$ 100.00
Hardship Waiver	$ -	$ -	$ -

It is our understanding that the goal in New York was to keep costs relatively low given that it is a simplified paper-based process. The same goal should apply with regard to Texas' new surprise billing arbitration law, since it is also designed to be a simplified paper review. TDI's publication of the standard fees for arbitration would also be helpful to those making a cost-benefit analysis in deciding whether to request arbitration.

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

As TDI is aware, the language in SB 1264 provides for a limited review by an arbitrator, based upon consideration of documents submitted by the parties in response to the 10 factors delineated in the bill. The timeframe for this paper-based review is relatively short (unless otherwise agreed to by the parties). Further, the law expressly provides that a party may not engage in discovery

[1] Note that this information may have changed. But, this is the latest information that we had on the fees.

in connection with the arbitration. All of these provisions of the law (regarding timing and scope of the surprise billing arbitration process) would, on their face, seem to reduce the availability of a meaningful opportunity to rebut any information another party submitted to an arbitrator (especially since the law does not contemplate a meeting or hearing).

Thus, to promote the most efficient and cost-effective resolution of claims, the Associations generally do not believe that there should be an opportunity to rebut the information another party submitted to an arbitrator. However, if the arbitrator needs to contact one of the parties for clarification on the information submitted, that should be permitted. Since the law does not permit discovery, TDI should promulgate rules to hold insurers accountable and take enforcement actions against health benefit plan issuers that submit information that they know to be false (as some of the information may not be capable of being independently verified by the physician parties to arbitration).

Additionally, TDI may consider promulgating an exception to the rebuttal prohibition if the parties agree to permit a rebuttal (and agree to any extensions and added arbitrator costs necessary to review the rebuttal information). In this scenario, the rules would need to be clear that a rebuttal is limited to the factors listed in the bill (and does not otherwise expand the scope of the review or change the paper-based nature of the review). If rebuttals are allowed in agreed-to scenarios, it would also be important for TDI to require each party to file copies of their submissions with the other party at the same time that they file the copy with the arbitrator and to impose timeframes that allow equal opportunity for response and only one rebuttal opportunity (and one follow up reply by the other party) in order to keep the process moving.

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

We believe that clear rules on each step of the arbitration process should be promulgated by TDI, including on this point. TDI should develop an easy process through its portal to facilitate submission of this notice, as well as any other necessary communications with the Department.

D. Are rules needed to address fees and standards for arbitrators?

As stated earlier, in Section II.A., of this comment letter, reasonable fees for arbitrators will be critical to ensuring access to the process, which is imperative for fairness in settlement of out-of-network billing disputes that fall within the scope of Senate Bill 1264. Thus, rules are necessary to address fees for arbitrators.

In developing rules on fees for the arbitrators, TDI should develop rules that set maximum reasonable fees, including expenses, for arbitrators. It is imperative that the arbitrator's fees, including expenses: (1) are set at a rate that ensures the process is not cost prohibitive and (2) are well below the cap on the bundled claims' amount in controversy. Methods for reducing the arbitrator's fees (as discussed in Section II.A. of this comment letter should be explored by the Department).

TDI should set by rule an amount that constitutes a reasonable fee for the arbitrator based upon the claim's progression in the arbitration process, including specifying a reasonable fee: (1) for

instances in which the parties to an arbitration reach an agreed-to settlement after the arbitrator was selected but before the arbitrator made a decision; and (2) for a full review under the subchapter that includes a decision. If the parties reach an agreed-to settlement of a dispute over a claim that was the subject of an arbitration request prior to the selection/engagement of an arbitrator, no arbitrator fee should be permitted. If the commissioner sets an application fee, this fee must be reasonable and must be taken into consideration when setting the arbitrator's fee/costs (in order to ensure that the total of all fees and expenses related to the arbitration are reasonable and not a barrier to accessing the arbitration process).

The bill also contains limited language regarding qualifications for arbitrators. Specifically, it provides that:

> (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.

In order to ensure that the person making these out-of-network claims dispute resolution decisions is properly qualified, TDI should promulgate rules elaborating on the qualification requirements. For example, among the factors to be considered by an arbitrator under the bill are some factors that require clinical expertise (e.g., consideration of the circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service and supply). In order to be qualified to assess the clinical factors, if the arbitrator is not a physician in the same or similar specialty as the physician who provided the services included in the claim dispute, the arbitrator should be required to consult with a physician of the same or similar specialty in order to properly weigh the clinical factors.

Once again, the Associations note that the Texas law (SB 1264) was modeled after the New York law and the New York law mandates that the IDR entity use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process.

III. Issue 3: Payment standards and hold harmless

Next, in Issue 3, TDI notes the following:

> 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 networks. Current TDI rules establish payment

> standards for these situations to minimize balance billing to consumers and prohibit balance billing for HMO members.

TDI continues by asking: 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 networks?

Presumably, in this question in the stakeholder notice, TDI is referencing Section 1271.055 of the Texas Insurance Code (which was not amended by SB 1264), as well as the rules implementing that section of the law (i.e., portions of 28 TAC 11.1611 and 28 TAC 11.1607). the Associations generally support TDI's existing rules implementing §1271.055 of the Texas Insurance Code. The Associations contend that, consistent with current TDI interpretations and rules, an HMO should be required to hold its enrollee harmless in these scenarios. The statutory provision that TDI is implementing (§1271.055 of the Texas Insurance Code) is designed to ensure that HMO enrollees purchase a meaningful product and are able to receive medically necessary covered services when a network provider is not reasonably available (e.g., when there is inadequate network). Thus, it makes sense that the HMO should be responsible for shortcomings in its networks under these scenarios (rather than shifting that responsibility on to the enrollee or the physician or provider).

Under existing TDI rules, our understanding is that the HMO would be required to pay the usual and customary rate as an initial payment, but it would ultimately be responsible for holding the enrollee harmless (i.e., paying an amount sufficient to ensure that a balance bill is not issued to the enrollee). This framework is favorable to the enrollee, as it protects the enrollee from a balance bill. Additionally, it enables the physician or provider to avoid pursuing arbitration. However, the Associations note that general payment methodology language in this section of the rule contains only loose parameters for calculation of reimbursements. Further defining usual and customary rate for purposes of the initial payment in this context (which certainly should be defined as above in-network rates) may be helpful to ensure that health plans are complying with their initial usual and customary rate obligation under the rule.

In a related rule (i.e. 28 TAC 11.1607(j)), TDI states that an HMO that is unable to meet certain network adequacy requirements must file an access plan for approval with the department and the access plan must specify certain elements. The Associations generally support the elements in the access plan; however, we would recommend that the rule be strengthened to place an increased emphasis on network adequacy by, for example, amending (j)(5), which currently states the following:

> (5) a list of the physicians or providers within the relevant service area that the HMO attempted to contract with, identified by name and specialty or facility type, with:
>
> (A) a description of how and when the HMO last contacted each physician, provider, or facility; and
>
> (B) a description of the reason each physician, provider, or facility gave for declining to contract with the HMO.

The Associations would recommend that, in addition, to the above requirements, TDI require the HMO to include (along with the list of the physicians or providers with whom they attempted to contract) the contact information (phone number, email, and mailing address) for the physician or provider (as well as the name and contact info for any physician or provider representative with whom the plan engaged in contract discussions) so that TDI can more readily audit the HMO's representations regarding contracting attempts. The HMO should also be required to include information about what contract term, if any, was the basis of the failure to contract and provide information on any attempts the HMO or physician/provider made to negotiate that term. (Similar additions should be included in the waiver requests in the PPO/EPO rules).

The Associations note that after the passage of SB 1264, network adequacy does not become any less critical of an issue than it was prior to SB 1264. When selling a managed care product (particularly a network-based product), much of the value of the product is determined by how robust the network is. Texas enrollees must have assurances that the products being sold in Texas are adequate in all areas previously addressed in TDI rules. As the Department knows, it was not the Legislature's intent to relieve health plans of network adequacy requirements by promulgating SB 1264 (as evidenced by the fact that all the network adequacy requirements previously in Texas law remain intact, along with some new additions recently passed by the Legislature). Rather, the Legislature was attempting to create a backstop to take the patients out of the middle of out-of-network disputes when they nonetheless occur and the patient did not elect to have the care out-of-network (despite requirements to have adequate networks). Thus, TDI's role in promulgating rules on network adequacy and taking enforcement actions remains critical to the proper regulation of the insurance industry in Texas. We appreciate TDI's continued efforts, including many notable recent efforts, to this end.

IV. Issue 4: Benchmarking

Next, in issue 4, TDI notes that the bill provides that the TDI commissioner may adopt rules governing the submission of information for the benchmarking database. And, specific to that submission, TDI asks: what rules, if any, are needed related to submission of information to the benchmarking database and how that information is used?

In response, the Associations contend that TDI should develop rules requiring health benefit plan issuer/administrator submission of claims (including the data necessary for the specific data points referenced in the bill) to the benchmarking database selected by the commissioner (in accordance with the law). The commissioner should require the plan issuers and administrators to submit the claims information at such intervals and for such time periods as is necessary to ensure that the benchmarking data used in the out-of-network claims dispute resolution process under Chapter 1467 is sufficiently up-to-date to reflect the current market (and to ensure that the health plans are not cherry picking data submission in order to alter the outcomes of arbitration).

At a minimum, TDI should require health plan issuer/third party administrator data submissions to the selected benchmarking database as is required/recommended by the selected database or on a monthly basis, whichever is more frequent. This will allow the database to run any validation necessary on the claims and to provide updates in a timely manner. TDI should conduct regular audits on health plan data submissions to ensure compliance with the law and rules. If a health plan is failing to submit data, partially submitting data, altering data, or

intentionally falsifying data, strong enforcement by TDI will be necessary and imposition of penalties must be imposed by TDI in order to protect the integrity of the process.

Further, the Associations ask that the Department develop rules that make it clear that TDI is responsible for providing the data points from the benchmarking database to the arbitrator (i.e., under Sections 1467.083(b)(6)(7) and (9) of the law). Since the benchmarking data points required for consideration by the arbitrator will likely require a license in order to access to the database, requiring physicians or health care providers to provide the data will be yet another expense and potential barrier to utilization the arbitration process. It is imperative that TDI assume that responsibility in order to promote fair access to the arbitration process.

Finally, TDI asks specifically if any "rules are 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 service or supplies in the same region.'" the Associations note that the bill already contains multiple reference to "geozip," which is a specifically defined term. Although "region" is not specifically defined in the bill, its use in the context of Section 1467.083(b)(1)(B) reflects the need for an interpretation consistent with geozip in order to provide a consistent data point for comparison in the bill. The bill clearly intends for geozip to be the relevant region (i.e., market) when assessing both payments and billed charges (as reflected in other provisions of Section 1467.083). Section 1467.083(b)(1)(B) should not depart from that general framework. We also feel that data usage at the "geozip" level would be the most accurate for the process laid out in SB 1264.

V. Other Issues for Consideration

Finally, TDI asks if there are other issues that should be considered for potential rulemaking in order to implement SB 1264. Certainly, we will supplement this list as we continue to contemplate the implementation of the bill. However, we have included a few initial issues for TDI's consideration, below.

A. Bundling of Claims

In Section 1467.084(e) of the Insurance Code, as added by SB 1264, it discusses bundling of claims into one arbitration proceeding. In (e)(1), it states that TDI rules must provide that the total amount in controversy for multiple claims in one proceeding may not exceed $5,000. TDI should make it clear in its rule that by "amount in controversy" in this provision, the bill means the balance unpaid for the health care or medical service or supply that is the subject of the arbitration after the health benefit plan issuer's or administrator's initial payment/modified payment after internal appeals (and after any copayments, coinsurance, and deductibles for which an enrollee may not be billed). In other words, the full billed charge is not the "amount in controversy" for purposes of capping claims that may be bundled.

Additionally, we recommend that TDI consider adopting a rule that would allow physicians in the same group practice who are in the same specialty to submit bundled claims involving the same health benefit plan issuer if those claims otherwise meet the requirements of the bill (e.g., amount in controversy, etc). Such a rule would make the arbitration process more accessible to physicians in small practices.

B. Exclusivity of Arbitration Factors

In TDI's rules, TDI should make it clear that the factors that an arbitrator must take into account under Section 1467.083(b) are the only factors to be considered by the arbitrator in determining a reasonable amount for the health care or medical services or supplies provided by an out-of-network provider. In other words, an arbitrator is not permitted to take into consideration a fee or rate set by Medicare, Medicaid, Tricare, or an indigent health program.

C. Global Billing Issues

Finally, we note that the professional component of a physician service is the physician's work interpreting or providing the service. The technical component of a physician service includes the provision of all equipment, supplies, personnel and costs related to the performance of a service. Physician services may be a combination of the two components or they may be two distinct components of a service.

Radiology services may be billed with the professional and technical components on different claims, for different providers. That is not to say that the two components may not sometimes be billed on the same claim. It all depends upon where the service was provided and who interprets the x-ray.

For example, an x-ray is performed in a freestanding radiology clinic. A physician who is not employed by the freestanding radiology clinic interprets the x-ray. The radiology clinic would bill insurance for the technical component since they provided the equipment to perform the x-ray. The physician would submit a separate claim for the professional component since they interpreted and provided a written report of the results of the x-ray. If this same radiology service had been provided in a physician's office and the physician also interpreted the x-ray then they would be billing both the professional and the technical component of the service.

Pathologists and independent laboratories are allowed to bill both the professional and technical components of pathology services they provide. In fact, professional component billing is a recognized method of billing for professional services of pathologists in the clinical laboratory. If a health plan is paying a facility for laboratory services, it does not take into account the pathologist's services in that reimbursement. Therefore, the pathologist may seek separate professional component payment directly from the insurance company. CPT coding supports that modifier 26 (professional component of a service) can be used for medical direction, supervision and/or interpretation for all laboratory CPT codes. The pathologist is not considered a facility or part of the facility billing.

TDI should make it clear that globally billed physician services composed of both a professional and/or technical component are subject to ADR. If however when these services are provided in a facility and are billed separately (technical and professional), the physician's professional component should be subject to arbitration and the facility's technical component should be subject to mediation laws.

VI. Conclusion

Once again, we thank you for the opportunity to provide these comments. If you have any questions please do not hesitate to contact any of the Associations referenced in this letter.

Sincerely,

David C. Fleeger, MD
President
Texas Medical Association

G. Ray Callas, MD
President
Texas Society of Anesthesiologists

Hemant Vankawala, MD, FACEP
President
Texas College of Emergency Physicians

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Darlene Metter, MD
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Gregory Hosler, MD, PhD
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Chair of the Board
Emergency Department Practice Management Association (EDPMA)

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

August 8, 2019

VIA ELECTRONIC MAIL to comments@tdi.texas.gov

Comments
Texas Department of Insurance
Austin, Texas

Re: Stakeholder meeting on Senate Bill 1264 rules

Dear Commissioner Sullivan,

On behalf of the Texas Medical Association ("TMA"), we appreciate this opportunity to offer additional comments on the Texas Department of Insurance's ("TDI" or "the Department")'s efforts to implement SB 1264. In particular, we would like to comment on the question posed by you at the SB 1264 stakeholder meeting on July 29, 2019 regarding the threshold issue of the extent to which TDI has jurisdiction over the subject matter of SB 1264 and more specifically, the regulation of physicians subject to SB 1264.

At the stakeholder meeting, your questions regarding authority/jurisdiction over the regulation of physicians in the context of SB 1264 were posed to TMA President, David C. Fleeger, MD. As Dr. Fleeger and you both noted at the time, Dr. Fleeger is a physician, not a lawyer. As such, Dr. Fleeger was present at the stakeholder meeting for the purpose of offering testimony concerning the operational aspects of SB 1264, not its legal implications. Thus, a jurisdictional/statutory authority question is outside of Dr. Fleeger's scope and has been referred by Dr. Fleeger to us, in our capacity as legal counsel for TMA, for response.

Consequently, we are writing this letter to clarify some points regarding TMA's position on the scope of TDI's jurisdiction/authority under SB 1264. First, we note that the plain language of SB 1264 itself makes it clear that, even in the context of SB 1264, the Texas Medical Board ("TMB")— not TDI—remains the state agency with regulatory and enforcement authority over Texas' physicians and the practice of medicine, which includes a physician's billing. After SB 1264, TDI's regulatory and enforcement authority remains where the Texas Legislature has always placed it (i.e., focused on state-regulated health benefit plan issuers in Texas).

With that being said, TDI does have certain express rulemaking authority regarding the implementation of the out-of-network claim arbitration process as set forth in SB 1264 and discussed more fully below. TDI's rulemaking on arbitration, to the extent authorized by the Legislature, has a great potential to affect physicians as well as other health care providers in this state. However, it does not extend into regulating a physician's ability to bill and/or taking

enforcement actions against physicians (as discussed more fully, below). In promulgating rules to implement the arbitration process, it is imperative that TDI carefully abide by the bounds of its statutorily authorized rulemaking authority. TMA would strongly oppose any attempt by the Department to enforce the law and regulations against physicians.

I. Regulatory and Enforcement Authority With Regard to Physicians Subject to SB 1264 Remains with the TMB, Not the TDI.

Under existing law, the Texas Legislature has consistently recognized the TMB as the primary means of licensing, regulating, and disciplining physicians.[1] The Legislature included language expressly stating this intent in the Medical Practice Act itself[2] and reiterated the TMB's overarching authority over physicians through numerous other statutory provisions, including through its broad grant of authority to the TMB to: (1) regulate the practice of medicine in this state[3] and (2) discipline physicians for committing an act that violates any state or federal law if the act is connected with the physician's practice of medicine.[4]

Similarly, the Texas Legislature has recognized TDI as the state agency responsible for the regulation of the business of insurance in this state.[5] The plain language of SB 1264 does nothing to disturb this well-established, longstanding statutory framework, setting forth separate jurisdictional spheres for these two state agencies. In fact, the Legislature included numerous provisions in SB 1264 itself that not only recognize but also *reinforce* the respective, bifurcated jurisdictions of these two state agencies.

A. As Stated in SB 1264, Enforcement of Violations of SB 1264's Prohibition on Balance Billing or a Law that Imposes a Requirement Related to that Prohibition Resides with the TMB as Applied to Physicians.

First, Section 752.0003 of the Texas Insurance Code, as added by SB 1264, which sets forth enforcement authority regarding violations of SB 1264's prohibitions on balance billing, states as follows:

> Sec. 752.0003. ENFORCEMENT BY REGULATORY AGENCY. (a) An appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition.

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[1] TEX. OCC. CODE §151.003.
[2] *Id*.
[3] See, e.g., TEX. OCC. CODE §§ 152.001and 153.001(3).
[4] TEX. OCC. CODE §§164.051(a)(1); 164.052(a)(5); 164.053(a)(1).
[5] TEX. INS. CODE §31.002(1).

> (b) The department may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.
> (c) A regulatory agency described by Subsection (a) or the commissioner may adopt rules as necessary to implement this section. Section 2001.0045, Government Code, does not apply to rules adopted under this subsection.

Under the express statutory language of Section 752.0003, the TMB, as the "appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician… to practice…in this state" is the agency with the authority to take disciplinary action against a physician who violates a law that prohibits the physician from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's participant's or enrollee's managed care plan or that imposes a requirement related to that prohibition. Conversely, TDI does not "license[], certif[y], or otherwise authorize[]" a physician to practice in this state and, therefore, very clearly falls outside this express grant of statutory authority for enforcement related to the bill.

Consistent with the TMB and TDI's existing statutory authority (and the traditional jurisdictional scope of the respective state agencies), the Legislature intended a bifurcation in enforcement authority here—the health care licensing/certifying agencies enforce the law with regard to health care providers within their respective jurisdictions and TDI enforces the law with regard to health plan issuers in its jurisdiction. This fact is made abundantly clear with the language in subsection (b) that further specifies that "TDI may take disciplinary action *against a health benefit plan issuer or administrator* if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure."

Furthermore, subsection (c) authorizes a regulatory agency described by subsection (a) or the commissioner, respectively, to adopt rules necessary to implement the section. From the context of the law, it is clear that the scope of those rules must be consistent with the bifurcated authority listed in subsections (a) and (b). In other words, the state agencies regulating health care providers are authorized to promulgate rules regarding enforcement provisions applicable to the health care providers within their respective jurisdictions, and TDI is authorized to implement rules regarding enforcement provisions applicable to health benefit plan issuers and administrators within its jurisdiction.

Next, Section 752.0002 of the Texas Insurance Code, as added by SB 1264, states as follows:

> Sec. 752.0002. INJUNCTION FOR BALANCE BILLING. (a) If the attorney general receives a referral from *the appropriate regulatory agency* indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement

related to that prohibition, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation.
(b) If the attorney general prevails in an action brought under Subsection (a), the attorney general may recover reasonable attorney's fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action. (emphasis added).

The Department will note that subsection (a) refers to "the appropriate regulatory agency" making a referral regarding a pattern of intentionally violating a law that prohibits balance billing or that imposes a requirement related to that prohibition. "The appropriate regulatory agency" for purposes of referring alleged violations by Texas physicians is, once again, the TMB and "the appropriate regulatory agency" for purposes of referring alleged violations by Texas health plan issuers/administrators is the Department. The Legislature used the "appropriate regulatory authority" language for economy of words in order to avoid listing all affected regulatory agencies individually, given the wide array of individuals and entities falling within the scope of SB 1264 while, once again, simultaneously recognizing the division of enforcement responsibilities between state licensing agencies for health care providers and TDI for health plan issuers/administrators as referenced in the subsequent section of the law (i.e., Section 752.0003, Texas Insurance Code).

Recognition of the Legislature's bifurcation of enforcement authority in SB 1264 is vital to ensuring that there is proper vetting by the licensing agency that has enforcement authority prior to referral to the attorney general in order to avoid undue burden and expense to both the state and the affected health care provider or health plan issuer/administrator. It is important that TDI honor this statutory language and its intended division of authority. Thus, under the express terms of the law, TDI is only authorized to refer alleged violations regarding health benefit plan issuers and administrators to the attorney general.

B. As Stated in SB 1264, Express Authority to Enforce the Bad Faith Arbitration Provisions and Any Other Violation of Subchapter B-1 of Chapter 1467 Applied to Physicians Resides with the TMB.

Next, in Section 1467.101 of the Texas Insurance Code, as amended by SB 1264, the Legislature sets forth various conduct that constitutes bad faith participation in arbitration. Once again, by its plain language, the Legislature made it clear that TMB is the state agency with enforcement authority over an alleged physician violation of this provision (as well as over any violation of Subchapter B-1—*the entire arbitration subchapter*) by stating in Section 1467.102(a) that "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." Very clearly this is, once again, a grant of enforcement authority to the respective licensing body for the actor (i.e., the TMB as applied to physicians and TDI as applied to health benefit plan issuers who are granted a license or certificate of authority to operate in Texas).

C. As Stated in SB 1264, Investigations and Complaints That Relate to the Settlement of An Out-of-network Health Benefit Claim Subject to Chapter 1264 As Applied to Physicians Remains with the TMB.

Finally, in Section 1467.151(a) of the Texas Insurance Code, the Legislature once again makes explicit in its regulatory and enforcement framework that authority for investigating and reviewing complaints filed that relate to the settlement of an out-of-network health benefit claim that is subject to Chapter 1467 remains with the respective agency with traditional jurisdiction over the individual or health plan issuer (i.e., "The commissioner and the Texas Medical Board or other regulatory agency, as appropriate, shall adopt rules regulating …"). This division in regulatory/enforcement authority is further evidenced in subsection (b) which notes that "the department and Texas Medical Board or other appropriate regulatory agency shall maintain information on each complaint that concerns a claim, arbitration, or mediation subject to this chapter, including . . . (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*." (emphasis added).

Taken in total, the enforcement provisions discussed above (i.e., §§ 752.0002-.0003, 1467.101-.102, and 1467.151, Insurance Code) cover the entire scope of the subject matter of SB 1264 as applied to physicians from the prohibition on balance billing (or a law that imposes a requirement related to that prohibition) to the arbitration process to investigation of complaints related to the settlement of an out-of-network health benefit claim subject to Chapter 1467. Thus, it is readily apparent from the plain language of SB 1264 that the Texas Legislature intended for the TMB—and not TDI—to enforce SB 1264 as applied to physicians.

II. SB 1264 Granted TDI Limited Rulemaking Authority Related to the Arbitration Process. That Rulemaking Authority Does Not Extend to the Regulation of Physician Billing.

A. TDI's Rulemaking Authority Is Limited to the Arbitration Process Itself.

As stated above, the Legislature has made it abundantly clear that enforcement over alleged physician violations associated with SB 1264 lies with the TMB (both through specific provisions in the bill and the TMB's general enforcement authority over physicians committing an act violating state or federal law if the act is connected with the physician's practice of medicine). Thus, TDI's authority (including rulemaking authority) does not, in any way, extend to enforcing SB 1264 against physicians. Additionally, TDI's rulemaking authority under SB 1264 does not extend its policy-making authority to encompass the regulation of a physician's ability to bill (which falls squarely within the jurisdiction of the TMB).

Rather, SB 1264 grants the following rulemaking authority to TDI, which is limited to the arbitration process itself:

- Section 1467.082(b)—requires the commissioner to: (1) 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 may be submitted and (2) maintain a list of qualified arbitrators for the program;

- Section 1467.084(c)—requires the person who requests the arbitration to 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;

- Section 1467.084(e)—requires the commissioner to adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding;

- Section 1467.086(d)—requires the commissioner to immediately terminate the approval of an arbitrator who no longer meets the requirements of the subchapter and rules adopted under the subchapter to serve as an arbitrator; and

- Section 1467.088(c)—requires the arbitrator to 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, it requires the parties to provide written notice in the form and manner prescribed by commissioner rule of the amount of the settlement.

The other legislative grants of rulemaking authority to TDI under SB 1264 are limited to TDI's traditional scope of regulation (i.e., regulation of health benefit plan issuers and administrators) or apply in the context of mediation which does not apply to physicians. Among those provisions are the following:

- Section 752.0003(c)—allows the Department to adopt rules as necessary to implement the section (regarding disciplinary action against a health benefit plan issuer or administrator for violating a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure).

- Sections 1271.008(a)(3), 1301.010(a)(3), 1551.015(a)(3), 1575.009(a)(3), and 1575.009(a)(3)—requires an explanation of benefits provided to the physician or provider to include information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467;

- Section 1467.003(a)—requires the commissioner, the TMB and any other appropriate regulatory agency to adopt rules as necessary to implement their respective powers and duties under Chapter 1467;

- Section 1467.006(d)—authorizes the commissioner to adopt rules governing the submission of information for the benchmarking database used in the arbitration process;

- Sections 1467.0505(b)(1), 1467.052(d), and 1467.054(b-1)—concern commissioner rulemaking related to mediation (which only apply to a health benefit claim submitted by an out-of-network provider that is a facility); and

- Section 1467.151(a)—requires the commissioner and the TMB or other appropriate regulatory agency, as appropriate, to 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 Chapter 1467, Insurance Code.

Historically, TDI has recognized the limitations of its jurisdictional authority with regard to balance billing issues. For example, in the 2013 Biennial Report to the Legislature, TDI noted the Texas Legislature is the "only entity with policymaking authority over all parties" in balance billing/out-of-network claims disputes and that TDI's preferred provider benefit plan (PPO) rules represented "TDI's best efforts to protect consumers and meet legislative mandates within the confines of TDI's authority."[6]

Nothing in SB 1264 has changed the jurisdictional limits of TDI's authority to now permit it to regulate a physician's ability to bill or charge.

B. TDI's Rulemaking Authority Does Not Extend to the Out-of-Network Disclosure Exemption.

Given the context above of TDI's limited rulemaking authority under SB 1264, it is important to revisit a subject of much discussion at the stakeholder meeting on July 29 (i.e., that regarding the out-of-network disclosure exception to SB 1264's prohibitions on balance billing).

The out-of-network disclosure exceptions under SB 1264 (i.e., §§ 1271.157(d), 1271.158(d), 1301.164(d), 1301.165(d), 1551.229(d), 1551.230(d), 1575.172(d), 1575.173(d), 1579.110(d), and 1579.111(d)) permit a physician to balance bill where otherwise prohibited under the law for a nonemergency health care or medical service:

(1) That an enrollee elects to receive in writing in advance of the service with respect to each non-network physician or provider providing the service; and
(2) For which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:
    (A) Explains that the physician or provider does not have a contract with the enrollee's health plan;
    (B) Discloses projected amounts for which the enrollee may be responsible; and
    (C) Discloses the circumstances under which the enrollee would be responsible for those amounts.

[6] See pp. 37-38 of TDI's Biennial Report to the 83rd Legislature (December 2012), *available at*: https://senate.texas.gov/cmtes/83/c510/QR13_1-TDI-BiennialReport83.pdf.

Importantly, the disclosure exceptions listed above determine when a physician may balance bill. As noted above, this is a subject matter that *TDI itself* has noted to be outside of its jurisdiction[7] (and which continues to be outside of TDI's jurisdiction after the passage of SB 1264).

Laws regulating physician billing have been, and continue to be, within the purview of the TMB. For example, the TMB has authority to take action against a physician who violates Section 311.0025, Health and Safety Code, which prohibits a physician from submitting to a patient or a third party payor a bill for a treatment that the professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.[8]

The TMB has taken many disciplinary actions against physicians related to billing issues, including improper billing violations. *See Attachment A* from some examples from the TMB's Bulletins.

Additionally, it is important to note that the very definition of "practicing medicine" as set forth in the Texas Medical Practice Act includes billing for services.

> 'Practicing medicine' means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method or the attempt to effect cures of those conditions, by a person who:
>
> (A) Publicly professes to be a physician or surgeon; or
> (B) *Directly or indirectly charges money or other compensation for those services.*[9]

For TDI to attempt to regulate physician billing (and implement the disclosure form exceptions of SB 1264) would be an attempt to regulate the practice of medicine and is, therefore, outside its statutory authority. Once again, as noted above, the TMB is the state agency with the power to regulate the practice of medicine, not TDI.

Certainly, given SB 1264's numerous (over 15) references to commissioner rules, the Texas Legislature was well aware of its ability to grant TDI rulemaking authority under SB 1264 when and where it so desired if it wanted to alter the existing jurisdictional spheres of the agencies. However, it declined to do so with regard to the disclosure exceptions to the prohibition on balance billing. This declination (along with the express enforcement framework under SB 1264 as applied to physicians being placed squarely and repeatedly with the TMB) clearly demonstrates the Legislature's deference to the traditional jurisdictional scopes of the TMB and TDI.

TDI should not disrupt the Legislature's well-established jurisdictional framework. If rules are to be promulgated to implement the disclosure exceptions under §§ 1271.157(d), 1271.158(d), 1301.164(d), 1301.165(d), 1551.229(d), 1551.230(d), 1575.172(d), 1575.173(d), 1579.110(d),

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[7] *Id.*
[8] See also, TEX. OCC. CODE §§ 101.203 and 164.053(a)(7).
[9] TEX. OCC. CODE § 151.002(a)(13). (emphasis added).

and 1579.111(d) of the Insurance Code, the TMB must be the agency developing and adopting those rules as applied to physicians (as the TMB has express statutory authority to adopt rules to perform its duties and regulate the practice of medicine in this state).[10] TDI certainly may provide input to aid the TMB in its development of those rules (with the goal of having more uniform rules across agencies), but the rules themselves are in the jurisdictional purview of the TMB as they entail the regulation of physicians.

Additionally, we see value in TDI working with the TMB to create a form to aid in utilization of the statutory exceptions to the prohibition on balance billing. As TMA noted in prior comments, this form should not be mandated by TDI (again, that would be outside of TDI's jurisdictional authority), but it should be made available by the TMB and TDI to facilitate the exception process.

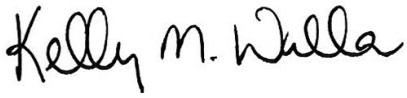
III. Conclusion

As the Commissioner of Insurance, we appreciate the seriousness with which you take compliance with the law, and we appreciate your inquiry into stakeholder opinions as to the appropriate scope of the Department's authority/jurisdiction in the implementation of SB 1264. We hope that this letter clarifies TMA's position on this matter.

Please feel free to contact us directly with any additional questions regarding statutory authority at TMA's general line at 800-880-1300 or at rocky.wilcox@texmed.org or kelly.walla@texmed.org.

Sincerely,

Donald P. "Rocky" Wilcox, JD
TMA Vice President and General Counsel



Kelly M. Walla, JD, LLM
TMA Associate Vice President and Deputy General Counsel

[10] TEX. OCC. CODE § 153.001.

ATTACHMENT A

Select Examples of TMB Disciplinary Actions Related to Billing
(All examples, below, are excerpted from TMB Bulletins)[11]

Marrow, Charles Taylor, III, M.D., Lic. No. E4006, Texarkana
On February 10, 2012, the Board and Charles Taylor Marrow, III, M.D., entered into an Agreed Order requiring Dr. Marrow to undergo an independent medical evaluation by a psychiatrist, have his practice monitored by a physician for eight monitoring cycles, pass within one year and within three attempts the Medical Jurisprudence Exam and complete within one year 16 hours of CME including eight hours in medical record-keeping and eight hours in supervising mid-level practitioners. The Board found Dr. Marrow failed to meet the standard of care, violated guidelines for standing delegation orders, improper billing, failure to adequately supervise and aiding or abetting unlicensed practice of medicine.[12]

Salzer, Thomas, M.D., Lic. No. J5638, College Station
On June 3, 2011, the Board and Thomas Salzer, M.D., entered into an Agreed Order requiring Dr. Salzer to complete within one year eight hours of CME in risk management and complete within one year an ICM-coding course with in-person attendance. The action was based on Dr. Salzer's unprofessional conduct when he submitted an improper billing statement.[13]

Elemuren-Ogunmuyiwa, Iyabo Abiola, M.D., Lic. No. K4050, Harker Heights
On October 18, 2013, the Board and Iyabo Abiola Elemuren-Ogunmuyiwa, M.D., entered into an Agreed Order publicly reprimanding Dr. Elemuren-Ogunmuyiwa and requiring Dr. Elemuren-Ogunmuyiwa to have her practice monitored by another physician for eight monitoring cycles; and within one year complete at least eight hours of in-person CME in the topic of proper billing practices. The Board found Dr. Elemuren-Ogunmuyiwa engaged in unprofessional conduct for improper billing. Specifically, Dr. Elemuren-Ogunmuyiwa was under investigation concerning her Tri-Care patient charts.[14]

Killyon, Garry W., M.D., Lic. No. M2673, Sugar Land
On May 1, 2014, the Board approved a Final Order requiring Garry W. Killyon, M.D., to within one year complete at least 25 hours of CME, divided as follows: 10 hours in medical record-keeping, 10 hours in CPT code billing, and five hours in ethics; have his billing practices monitored by a billing monitor for four consecutive monitoring cycles; and pay an administrative penalty of $5,000 within 60 days. The Board found Dr. Killyon in connection with his performance of surgeries and billing under CPT Code 11471, submitted billing statements that he knew or should have known were improper and failed to maintain medical records to support the billing for CPT code 15734. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the

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[11] *See TMB Bulletins for additional examples*: http://www.tmb.state.tx.us/docs/docs
[12] TMB Bulletin (March 2012) at p. 17; *available at*: http://www.tmb.state.tx.us/dl/8FF059B0-176A-943A-424E-5041AA8867B7
[13] TMB Bulletin (Jan. 2012) at p. 44; *available at*: http://www.tmb.state.tx.us/dl/D2AD4731-293E-5791-06AF-6D16BB612085
[14] TMB Bulletin (Dec. 2013) at p. 10; *available at*: http://www.tmb.state.tx.us/dl/2E5228C5-82E6-07E3-6CE4-E8ACEC322FAF

State Office of Administrative Hearings. Dr. Killyon has 20 days from the service of the order to file a motion for rehearing.[15]

Porto, Boris Joseph, M.D., Lic. No. H4621, Lubbock
On June 12, 2015, the Board and Boris Joseph Porto, M.D., entered into an Agreed Order requiring Dr. Porto to have his practice monitored by another physician for eight consecutive monitoring cycles; comply with the terms of his pre-trial diversion agreement with Texas Health and Human Services (HHSC) and provide evidence to the Board upon completion of the agreement; and within one year complete at least eight hours of CME in proper billing. The Board found Dr. Porto was subject to a pre-trial diversion agreement, entered in March 2014, with HHSC related to billing Medicaid for services "not rendered as billed" for patients in a group home.[16]

Lewis, Adolphus Ray, D.O., Lic. No. H2532, Fort Worth
On June 10, 2016, the Board and Adolphus Ray Lewis, D.O., entered into an Agreed Order After Formal Filing publicly reprimanding Dr. Lewis and requiring Dr. Lewis to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in proper billing practices and eight hours in ethics; and within six months pay an administrative penalty of $6,000. The Board found the evidence indicated a pattern of poor billing practices on the part of Dr. Lewis and that Dr. Lewis failed to document a minimal history for all patients at issue. This order resolves the formal complaint filed at the State Office of Administrative Hearings.[17]

Yarra, Subbarao, M.D., Lic. No. K3882, McAllen
On June 10, 2016, the Board and Subbarao Yarra, M.D., entered into an Agreed Order requiring Dr. Yarra to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in peripheral vascular intervention; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Yarra violated the standard of care with regard to eight patients by overestimating the true degree of stenosis on their angiographies and billed the patients for the procedures which lacked adequate documentation or justification.[18]

Mego, Pedro Antonio, M.D., Lic. No. M1925, McAllen
On June 10, 2016, the Board and Pedro Antonio Mego, M.D., entered into an Agreed Order requiring Dr. Mego to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in coronary angiography; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Mego violated the standard of care with regard to six patients. Three patient's carotid ultrasounds were based on inadequate documentation, and four patient's coronary computed tomographies were based on inadequate

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[15] TMB Bulletin (July 2014) at p.13; *available* at: http://www.tmb.state.tx.us/dl/9D3FDE49-E78B-A854-D28E-D55A72650EBB.
[16] TMB Bulletin (August 2015) at p. 15; *available at*: http://www.tmb.state.tx.us/dl/41514F2A-954E-F5CF-10F5-FBA7D75A28C9
[17] TMB Bulletin (July 2016) at p. 27; *available at*: http://www.tmb.state.tx.us/dl/3E6AEB22-664A-0ABF-F89B-25FB4B7979DD
[18] *Id*. at p. 13.

documentation, and therefore, were unnecessary. A coronary stent performed for one patient was also not indicated. Dr. Mego billed for these unnecessary procedures based on the inadequate documentation and failed to maintain adequate medical records for the patients.[19]

Mego, Carlos David, M.D., Lic. No. K6147, McAllen
On June 10, 2016, the Board and Carlos David Mego, M.D., entered into an Agreed Order requiring Dr. Mego to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least eight hours of CME in medical recordkeeping; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Mego violated the standard of care with regard to four patients whose ultra-sounds were based on inadequate documentation and were billed for the unnecessary diagnostic testing.[20]

Benavides, Richard Alex, M.D., Lic. No. F9189, Dallas
On August 25, 2017, the Board and Richard Alex Benavides, M.D., entered into a Mediated Agreed Order requiring him to within 60 days pay an administrative penalty of $4,000. The Board found Dr. Benavides did not document the necessary components to justify billing codes for five patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.[21]

Nawaz, Mohammad, M.D., Lic. No. L2497, Frisco
On August 25, 2017, the Board and Mohammad Nawaz, M.D., entered into an Agreed Order requiring him to have his billing practice monitored for 8 consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in ethics and eight hours in billing and coding; and shall comply with any and all terms of his Pre-Trial Diversion Agreement. The Board found that on February 20, 2015, Dr. Nawaz signed a Pre-Trial Diversion Agreement in U.S. District Court related to allegations of false billing claims.[22]

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[19] *Id*. at p. 12.
[20] *Id*.
[21] TMB Bulletin (September 2017) at p. 20; *available at*: http://www.tmb.state.tx.us/dl/A1BB2B98-02FD-3A3C-9022-D99248F0EEBF
[22] See p.12 of Texas Medical Board Bulletin, Sept. 2017; *available at*: http://www.tmb.state.tx.us/dl/A1BB2B98-02FD-3A3C-9022-D99248F0EEBF

July 15, 2019

VIA ELECTRONIC MAIL to comments@tdi.texas.gov

Commissioner Kent Sullivan
Texas Department of Insurance
333 Guadalupe Street
Austin, Texas 78701

Re: Stakeholder Meeting on SB 1264

Dear Commissioner Sullivan:

I am writing on behalf of the Texas Orthopaedic Association (TOA) to provide stakeholder comments on the upcoming rule related to SB 1264. TOA was founded in 1936 as a voluntary organization that seeks to ensure outstanding musculoskeletal care for Texas patients. Approximately 1,400 Texas orthopaedic surgeons are TOA members.

Issue 1: Nonemergency Exemption

- *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?*

TOA believes that it could be harmful to create an arbitrary deadline regarding when a patient must be presented with a notice regarding estimated charges prior to a service. It is true that many nonemergency surgeries may be scheduled several weeks in advance. However, it is also important to note that many musculoskeletal injuries require immediate attention, such as surgery, within a few days of the injury for proper healing. While these cases may need immediate attention, they are still defined as "nonemergency" and elective in nature, and it is critical to not delay these surgeries with a subjective deadline for a disclosure. As a result, TOA believes that it is appropriate to follow SB 1264 as it is written in statute to simply provide the disclosure prior to the surgery.

In addition, it is important to note that informed consent disclosures related to potential risks surrounding a surgery do not feature a definitive deadline as to when they must be disclosed. Instead, the state of Texas simply requires these disclosures to be made prior to a surgery. If the state views disclosures related to potential bodily risk at any point prior to the surgery to be adequate, then a financial estimate should be viewed the same way.

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

The reality is that a physician is unlikely to know the final charges that will actually owed by the patient for a variety of reasons:

- Physicians do not have access to a patient's latest insurance responsibilities. A physician does not know how much of a patient's deductible remains for the year.
- A surgeon goes into a surgery with a plan that is based on diagnostic testing prior to the surgery. However, these plans may change if the surgeon discovers issues that could not be identified by the diagnostic testing.

Ultimately, it is in the patient's best interest for the surgeon to address those unaddressed issues during the surgery. As a result, the codes that will be submitted to the patient's health insurance plan may not be known until following the surgery.

- Many commercial health insurance plans have started to use allowed charges as their basis for determining what a patient owes for out-of-network care. Physicians do not necessarily have access to a patient's allowed charge.

If TDI wants to make a serious attempt at providing a useful estimate to the patient, then the reality is that most of this burden will have to be placed on the commercial health insurance plan due to the plan's knowledge of the patient's deductible status.

If the commercial health insurance plan does not assume the burden regarding an estimate with real-time deductible information and information regarding what services the health plan will cover, then a physician should be tasked with providing general information, such as information regarding the fact that the patient will be responsible for his or her deductible, co-insurance, co-pay, etc. Ultimately, TDI should consider creating a template that all physicians can use. If a physician chooses to not use a TDI-produced template, the rules should provide protection for physicians to create a form of their own that a physician believes to be the most helpful for patients.

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

If a patient is under duress, the patient's well-being should be the ultimate concern. The plan for a surgery is typically based on diagnostics. If an additional issue is discovered during the surgery that needs to be addressed for the patient's well-being, then it does not make sense to require the surgeon to ignore that unexpected issue so that the patient can receive a financial disclosure at a later date.

Sincerely,

Adam Bruggeman, MD
President, Texas Orthopaedic Association

TEXAS SOCIETY OF ANESTHESIOLOGISTS

401 W. 15th, Ste. 990 • Austin, Texas 78701 • (512) 370-1659 • Fax (512) 370-1655
E-mail:info@tsa.org • Web site http://www.tsa.org

Dear Commissioner Sullivan:

The Texas Society of Anesthesiologists (TSA) represents approximately 3,700 physician anesthesiologists in the state of Texas and is a state component of the American Society of Anesthesiologists. As anesthesiologists are facility-based providers, the TSA has been extremely involved in the passage of 86R SB 1264 and we appreciate the opportunity to working on this important legislation through the rulemaking process at the Texas Department of Insurance (TDI). We look forward to participating in the July 29 stakeholder meeting and appreciate the opportunity to respond to your questions in advance.

Issue 1: Nonemergency exemption

A consumer may 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.

A. What rules, if any, are needed to provide adequate consumer certainty and protection? The Texas Society of Anesthesiologists would recommend that rules be adopted about the content of the exemption form provided to patients. Although we would not recommend a mandated form, promulgating a recommended form which physicians could use may be useful for independent practitioners or small groups.

1. **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?** The Texas Society of Anesthesiologists would not recommend a specific time frame, as what would work for an oncological surgeon may not work for an obstetrician or an anesthesiologist. Under Tex. Civil Practice and Remedies Code, §§ 74.101-74.107, physicians are required to provide informed consent for certain medical procedures prior to the performance of the procedure. No specific time frame prior to the procedure is specifically required (nor in 86R SB 1264) for providing the written consents, just that they be provided prior to

the medical service for each provider for which the insured patient accepts financial responsibility.

2. **What specific information must the disclosure include to ensure consumers understand the potential out-of-pocket cost for the service?** 86R SB 1264 is very clear on the three items which must be disclosed to a patient: a) that the physician or provider does not have a contract with the enrollee's health plan; b) the projected amounts for which the patient may be responsible; c) the circumstances under which the patient may be responsible for those amounts. The physician should disclose the first and the third in a plain language statement. While 86R SB 1264 places the burden of the disclosures on the physician or provider, it is important to note that a provider is not always knowledgeable of whether they are in a particular level of a carrier's network. The best information for both the patient and the physician or provider is the insurance carrier's provider network directories. It is crucial that these directories be up-to-date, accurate resources for both the patient and provider. If the provider can document they relied upon an inaccurate directory to determine whether a disclosure was necessary, then the provider should not be held liable for the inaccurate information. For the physician's disclosure of projected amounts, the physician has no option but to provide an estimate of billed charges. This should be accompanied by a statement that the projected amount is an estimate, not a final amount of billed charges, and could change based on emergent circumstances that arise during a procedure and could be higher or lower. This is particularly important for anesthesiologists and other anesthesia providers as anesthesia is billed in a three-part equation. The first is the base unit for the type of procedure, the second unit is based on the age, health, and condition of the patient, while the third is a consumption unit for the amount of time the patient is required to be under anesthesia. The time is something completely out of control of the anesthesiologist and is variable by procedure and by surgeon. This is prior to any unexpected complications. Thus, while an anesthesiologist may be able to provide an estimate or projected billed charges to a patient it is just an estimate until after the anesthesia is provided.

3. **What rules should TDI consider to prevent consumers from getting disclosures when they may be under duress?** This language is concerning to the TSA. Certainly, any patient preparing for a medical procedure from a physician providing a facility-based healthcare service is likely under some kind of duress. Patients planning for the joyous arrival of a new baby may be under duress by looming financial, social, or marital issues even for a healthy pregnancy. Conversely, patients receiving diagnostic imaging or surgical procedures to address chronic pain, cancer or deformities may be experiencing duress from stress or be under the influence of medication which may cause

impairment. No such language is included for a patient consenting to medical treatment under Tex. Civil Practice and Remedies Code §§ 74.101-74.107. The term "under duress" is a subjective term which could subject a physician to litigation. It is not contemplated by the statute and we would strongly discourage the TDI from adopting rules with such language.

Issue 2: Arbitration process

86R 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.

A. What rules, if any, are needed to ensure procedural fairness and meet the strict deadlines set by SB 1264? Rules should be explicit that the arbitration process is a document review only where the arbitrator reviews submitted documentation from the parties and the benchmarking database organization to determine appropriate payment within the guidelines provided in statute. Rules should be clear for arbitrators and for participants regarding guidelines for decision under the statute and what documents are required to be submitted to the arbitrator and under what time frames. The rules should also be explicit that the arbitrator shall only choose an initial payment or charge, a payment from an internal appeal over a coverage dispute or a settlement payment or charge offered during the informal settlement teleconference as their final decision amount. The rules should also be clear that payment of additional funds under a decision of the arbitrator shall be paid directly to the provider.

1. **Are there existing arbitration processes or models that should be considered?** While not identical, 86R SB 1264 was modeled after the New York balance billing dispute resolution process. Although it is called arbitration in the legislation, it is really an alternative dispute resolution process which requires submission of certain documents to be reviewed by a neutral who, based on specific guidelines laid out in statute determines which of five potential amounts – the initial charge for service, the initial payment by the health plan, the payment post appeal for coverage, or an offer from either party during an informal settlement tele-conference – is the appropriate amount for the service. New York does not have administrative rules to implement its statute, but has established a portal to submit a claim and answer frequently asked questions at the following website: https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills. The Texas law is designed to be a similarly simple process by which TDI operates a web portal for submission of the dispute with supporting documents and a request for resolution with

a Department appointed arbitrator. More than rules, a clear, well-functioning web portal with clear instructions for the arbitrator is critical. TDI should considered adopting a web form with a checklist for parties to fill out and attach required documents for the arbitrator to consider in their deliberations.

2. **To what extent should the process provide each party with an opportunity to rebut the information another party submitted to an arbitrator?** The arbitration envisioned in 86R SB 1264 is not meant to be a negotiation or arbitrated decision between the parties. The time frames are short because it is the intention that there is no discovery, face-to-face hearings nor the need for attorneys, but rather that the parties submit necessary documentation, and the arbitrator renders a decision based on that information. If the arbitrator has a question about the documents provided, they should have an opportunity to contact parties to clarify, but this should not evolve into rebuttals of evidence. The process should be no more than a choice the arbitrator must make between a potential of five options within a preordained set of guidelines.

3. **Are rules needed to address how and when the parties must notify TDI if they cannot agree on an arbitrator?** Under 86R SB 1264, parties must notify TDI of their lack of an agreement on an arbitrator within 30 days after the request for arbitration (the same time frame to achieve the informal teleconference). If a settlement is not reached during the teleconference and the parties have not agreed upon a non-TDI appointed arbitrator, then there needs to be a mechanism by which TDI is alerted or follows up with the parties. Again, equally or more important than the rules is the mechanism by which this process is done through the web portal.

4. **Are rules needed to address fees and standards for arbitrators?** Rules should be explicit that parties may choose to contract with a neutral of their choice by agreement before TDI assigns an arbitrator from its list of approved arbitrators. Arbitrator fees shall be split evenly. Since the statute has removed due process access and potential earnings simultaneously from physicians, it is important to ensure that the fee for arbitration is not cost prohibitive as an alternative dispute process, hence the efficacy of bundling of claims must be maintained through a cap on arbitration fees for commission appointed arbitrators. Rules should also be explicit about when arbitrators are paid and what should occur regarding payment of the arbitrator if the parties agree to a settlement under §1467.005 after the arbitrator is engaged but prior to a decision being rendered.

5. **Benchmarking data in the arbitration process.** Rules should be explicit that TDI shall make available to the arbitrator the data from the benchmarking organization for the charges and payment information for geozips related to the claim in question. TDI

should draw on available resources to designate appropriate geozip areas as defined by 86R SB 1264, which should be considered synonymous with regions.

Issue 3: Payment standards and hold harmless provisions

86R 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.

1. **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?** The TSA would not recommend any changes as SB 1264 did not amend the statute for access plans.

Issue 4: Benchmarking 86R SB 1264 provides that the Insurance Commissioner may adopt rules governing the submission of information for the benchmarking database.

1. **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*."** While region is undefined in the bill, it does require a benchmarking database to provide billed charges and in-network rates for a geozip, defined as an area with the same first three digits in the zip code. It is clear that the arbitrator is to compare charges and payments for similarly qualified out-of-network providers which could be competitors to the physician or provider which would indicate they were in the same market area. As the bill specifies that market area should be defined as a geo zip for two other data points and the trends for those data points, it would be illogical to add a different geographical area as a comparison market. Read as a whole, 86R SB 1264 uses the terms "geozip" and "region" interchangeably, and there is no difference in context.

2. **Data Submission.** 86R SB 1264 requires a benchmarking database chosen by the TDI to be able to calculate the 80th percentile of billed charges by geozip and the 50th percentile of in-network rates by geozip for specific procedures and by medical specialty of provider. These data points are utilized by the arbitrator for determining appropriate payments for OON services. Therefore, it is critical that the TDI adopt rules requiring carriers and third-party administrators in Texas to submit all claims data monthly to the

TDI which includes these references. Without complete records, carriers could submit partial, incomplete or just not report data which is disadvantageous to them to manipulate outcomes of arbitration.

3. **Benchmark Database Selection.** 86R SB 1264 requires the TDI to select an organization to maintain a benchmarking database. The organization must be an independent, non-conflicted organization free from any affiliation with a carrier, administrator, health care practitioner, or other health care provider. Further the organization must maintain databases of bill charges and of allowed rates to participating providers. The data should only include claims data from commercial and self-insured markets and exclude all government programs with rates set by the government. Maintenance of these databases must mean complete, recent data (which will necessitate data submission required by the TDI) which can be subset for each geo zip in this state for every health care or medical service or supply provided in a hospital, ambulatory surgical center, free standing emergency room or birthing center or for laboratory and diagnostic imaging service and supplies connected with an in-network provider. To ensure accuracy the data should be submitted monthly and validated.

Issue 5: Other considerations

Are there other issues or considerations that TDI should be aware of when drafting rules related to 86R 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.

1. **Usual and Customary Rate.** 86R SB 1264 requires an initial payment from the carrier paid directly to the provider within 30 or 45 days after the submission of a clean claim of an emergency or a covered non-emergency service or supply. That initial payment is required to be the usual and customary rate or an agreed to rate. It is necessary for the Texas Department of Insurance to adopt rules to define usual and customary for the various chapters of the Insurance Code. In Section 1551.003, Section 1575.002, and Section 1579.002 of the Insurance Code a new definition of "usual and customary rate" which is defined as "the relevant allowable amount as described by the applicable mater benefit plan document or policy" was added only for those chapters. Per the legislative intent set out at pages 1422 and 1423 of the House Journal it is clear that the new definition is limited to the state insurance programs described in Tex. Ins. Code Chapters 1551, 1575 and 1579. Whereas, the definition of usual and customary in Chapters 1271 and 1301, for HMO, PPO and EPO plans remains as the applicable definition under Chapter 843 and Chapter 1301, where the "usual and customary rate" is required to be

commercially driven and fairly and accurately reflective of current market rates, including geographic differences in cost.

2. **Deadlines and delivery of payment.** 86R SB 1264 allows a licensing agency to adopt rules regarding disciplinary action a licensing agency, including the Texas Department of Insurance, may take against a licensee for violations of the provisions of the bill. A new disciplinary action is available to licensing agencies under the legislation in that a licensing agency may refer a licensee to the Attorney General's office for a pattern of intentionally violating a law which prohibits a an individual or entity from billing an insured greater than the amount of the copayment, coinsurance, and deductible or imposing a requirement related to that prohibition. Since a provider may not seek further payment, from either the insured or through mediation or arbitration until a determination of coverage, an initial payment from the carrier and an accurate and timely explanation of benefits with itemized amounts is sent to the provider, it is essential that failure to comply is not only an administrative violation but that a pattern of intentional failure to comply warrants a referral to the Attorney General's office for injunctive relief. While, in multiple places in 86R SB 1264, it is clear that the penalty provision of §843.336 does not apply to the timely payment of a clean claim for out-of-network services, it does not specify that failure to timely pay is not an administrative violation that falls under the general rulemaking and enforcement authority of the agency in addition to the specific language in §752.0003.

3. **Due process when there is a coverage dispute.** 86R SB 1264 provides a process by which a health insurer and a health care facility or provider may resolve payment disputes over billed charges which remain after a carrier makes a payment and the insured pays for financial obligations under their policy for covered services. 86R SB 1264 specifically states that these types of disputes may not be litigated until administrative remedies through mediation or arbitration are completed (Pg. 49, Sec. 1467.085). However, if a carrier denies coverage for a service and upholds that decision through the carrier's internal appeals process mandated by the federal Affordable Care Act, there is no payment dispute applicable to Sec. 1467.085. Rather there is a coverage denial. Rules should make it clear that a facility or a provider with a claim for services which have been denied coverage are not subject to the exhaustion of the administrative remedies requirement and have all due process rights available to dispute a denial of coverage.

4. **Coverage of emergency care**. Recently, Anthem Blue Cross Blue Shield initiated a policy for emergency services where it retrospectively reviews care and may deny care based

on certain conditions. These exceptions include provider and ambulance referrals, services delivered to patients under the age of 15, visits associated with an outpatient or inpatient admission, emergency room visits that occur because a patient is either out of state or the appropriate urgent care clinic is more than 15 miles away, visits occurring between 8 a.m. Saturday and 8 a.m. Monday, and any visit where the patient receives surgery, IV fluids, IV medications or an MRI or CT scan. Many of these provisions directly contradict the mandated coverage of emergency services in 86R SB 1264 where emergency services are defined as having the prudent layperson definition under §1301.155. TDI should adopt rules which specifically require coverage of all emergency services as defined in statute until the patient may be transferred to an in-network provider.

5. **Clean Claim/Prompt Pay Language.** 86R SB 1264 requires physicians to submit claims in the manner detailed in §843.336 but does not apply the specific penalties against the carrier to be paid to the provider in §843. Thus, the rules may not be adopted by reference and require TDI to adopt rules specific to the requirements for submitting clean claims for out-of-network services. The rule should not only mirror the language of §843.336 for documentation submission but should specify the time frames for prompt payment of a clean claim which should be paid directly to a physician and not to an insured. Further, the rule should state that failure to comply is an administrative violation and an intentional pattern of violations could result in a referral to the Attorney General's office.

6. **Lab and Imaging Services.** Throughout 86R SB 1264 laboratory and diagnostic imaging services are required to be covered at the usual and customary rate or an agreed to rate if the services were provided in connection with an in-network physician or provider. The TSA recommends that TDI adopt rules which clarify the meaning of "in connection with an in-network physician or provider." If an in-network physician or provider orders laboratory or imaging services which are provided by an out-of-network physician or provider, then this language is not that confusing. But if an in-network physician orders an MRI on a minor who needs to be sedated and the out-of-network anesthesiologist orders diagnostic imaging to guide the insertion of a peripherally inserted central catheter, is the diagnostic imaging in connection with the in-network physician or the out-of-network physician? This gets murkier if the in-network physician is not a facility-based provider, perhaps a family physician. Perhaps language which states that laboratory and diagnostic imaging services are covered if provided in furtherance of a service requested or ordered by an in-network physician would help clarify.

7. **Teleconference.** Rules should be adopted to require the carrier to arrange the teleconference on a line with no expense for the provider. Rules should also require that any offer made during a teleconference by a carrier or provider which was not accepted as a settlement but which the party wishes to be considered during arbitration must be communicated to the other party as a settlement offer in writing prior to the 30th day after the date on which the arbitration was requested. This allows the other party a second chance to accept prior to arbitration and also provides documentation of the offer that is sent to the arbitrator as an offer from the teleconference to be considered under Sec. 1467.088.

8. **Bundling**. 86R SB 1264 requires TDI to adopt rules to allow physicians to bundle claims to arbitrate to a maximum amount of $5,000. Groups may submit a bundle of claims. It is common for health plans to have third party administrators act as their agents in claim processing and settlement. Likewise, physicians have insurance specialists for their groups which submit claims and handle settlement disputes. 86R SB 1264 states in Sec. 1467.084 that "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." Rules should be adopted which allow bundling by physicians of the same specialty in the same professional group of claims with the same carrier or third-party administrator. The rules should allow the group to act as the provider's representative.

9. **Selection of Neutrals.** Any neutral, whether mediator or arbitrator, should be impartial and independent and perform her or his duties carefully and in good faith. TDI should devise rules for disqualification of a neutral who shows: (1) partiality or lack of independence; (2) inability or refusal to perform her or his duties with diligence and in good faith; or (3) any grounds for disqualification provided by 86R SB 1264.

10. **Vacancies.** If for any reason a neutral cannot or is unwilling to perform, any vacancies should be filled based on the original procedures used to appoint the neutral.

The Texas Society of Anesthesiologists appreciates the opportunity to submit these comments in preparation for the stakeholder meeting on July 29, 2019 where we hope to provide further input and be as useful to the Department as possible in your task to draft the rules before the legislative deadline.

Sincerely,

Gerald Ray Callas, M.D.

President

AMERICAN SOCIETY OF PLASTIC SURGEONS ®
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July 15, 2019

The Honorable Kent Sullivan
Commissioner of Insurance
Texas Department of Insurance
333 Guadalupe
Austin, TX 78701

RE: Senate Bill 1264 rules

Dear Commissioner Sullivan:

On behalf of the Texas Society of Plastic Surgeons (TSPS) and the American Society of Plastic Surgeons (ASPS), we appreciate your consideration of our comments regarding the implementation of Senate Bill 1264 (S.B. 1264), which strives to protect patients from unanticipated medical bills. TSPS is the largest association of plastic surgeons in Texas, and in conjunction with our national affiliate, ASPS, we represent 653 board-certified plastic surgeons in the state. Our mission is to advance quality care for plastic surgery patients and promote public policy that serves patients.

We commend Senator Hancock, Representative Oliverson, the other members of the Texas Legislature, and Governor Abbott for their efforts to address this issue and appreciate their willingness to work with stakeholders in Texas to build upon the trailblazing surprise billing legislation that was passed in 2009. We also appreciate the transparent and inclusive process that the Texas Department of Insurance (TDI) is utilizing to implement S.B. 1264. To that end, please find our responses to your issues and associated questions as noticed by TDI[1]:

Issue 1: Nonemergency exemption

Patients need to be fully informed of their potential to receive care from out-of-network providers and that responsibility should fall on payers, facilities, and physicians. When it comes to the responsibility of the physician, we believe that the physician should, at minimum, give clear notice that: (1) the physician's services are not covered by the patient's health plan; (2) the patient's health plan has paid a rate below the physician's billed amount; and (3) there are remedies available to the patient, including alternative payment agreements and options for assignment. When it comes to timelines for how much advance notice consumers must be given before receiving a service that might result in a balance bill, we believe that TDI should follow the state's informed consent law and require only that the provider give notice before a procedure (thus foregoing a specific timeline). We believe that this is an appropriate and reasonable notification timeline for nonemergency services.

We would caution TDI to err on the side of patient safety when drafting rules related to patients receiving disclosures when they may be under duress. Myriad scenarios exist in which physician services cannot be delayed without patient harm. For example – the needed substitution of an out-of-network

[1] https://www.tdi.texas.gov/alert/event/2019/07/event29.html

anesthesiologist could occur immediately before the start of a scheduled procedure, or the performance of pathology services may be necessary while a patient is under anesthesia. Ethical and legal obligations prohibit physicians from delaying the provision of medical services based on insurance considerations.

Moreover, we caution TDI against requiring an itemized listing of the nonemergency medical care. This type of requirement would be inconsistent with coding and billing practices that are largely automated. Physician costs for services submitted to patients and payers are classified under the American Medical Association's Current Procedural Terminology (CPT) that is recognized by the federal government, standardized throughout the healthcare insurance sector, and highly nuanced.

Issue 2: Arbitration process

The New York State Surprise Bill Law, enacted in 2015, is one of the most successful out-of-network state policies in place to date. Due to its similarities to the New York law, we are encouraged that S.B. 1264 will result in a fair solution for Texas' patients, physicians, and insurers.

When it comes to arbitration of nonurgent unanticipated medical bills under the New York model, the patient may assign their benefits to the provider, completely removing the patient from the billing dispute. This allows the provider and carrier to negotiate fair reimbursement. If the parties cannot agree upon appropriate reimbursement, the carrier and provider may enter the state's binding independent dispute resolution (IDR) process.[2]

During the dispute resolution process, reviewers – who have experience in healthcare billing, reimbursement, and usual and customary charges – consult with a licensed physician in active practice in the same or similar specialty as the physician in question. Through baseball arbitration, the IDR selects one of amounts submitted by the carrier or physician. This successful paradigm has led to a reduction of out-of-network billing by 34 percent, resulted in a roughly even split in decisions between physicians and insurers, and is viewed as fair by physicians and insurers. Moreover, reports about surprise out-of-network bills went from being one of the top consumer complaints in New York to "barely an issue."[3]

Because of the overwhelming, proven success of the New York model, we recommend that TDI incorporate as much of that model within the parameters of S.B. 1264 to ensure that Texas' patients and physicians are represented fairly and have the ability to resolve billing disputes in a timely manner.

Finally, due to the fact that the binding arbitration process involves each party submitting its best-and-final offer, the ability to rebut information that is submitted to the arbitrator would not fall under the purview of the process outlined in the bill. Therefore, that should not be an option provided in the final rule.

Issue 3: Payment standards and hold harmless provisions

Since the passage of the Affordable Care Act, insurers have created products with narrow, inadequate, and non-transparent networks. These products have been created specifically because their narrow networks make them highly-profitable and relatively inexpensive for consumers. Texans who purchase these products are – unwittingly – subjected to those narrow networks, not realizing that the substandard networks are driving the cost of the insurance product lower. This creates the problem of more physicians

[2] https://www.dfs.ny.gov/IDR

[3] http://chirblog.org/new-york-law-surprise-balance-billing/

being forced out-of-network by the insurance companies, and not enough in-network physicians for patients to see.

In an effort to protect enrollees with plans that offer inadequate networks, we encourage the state to require all plans to offer out-of-network options. This will ensure that patients have voices when their payer network does not have adequate physicians to meet their health care needs. Furthermore, when a network provider is not available to meet a patient's need and a non-network provider must deliver care, insurers should compensate the provider at the physician's full out-of-network fee as a penalty for having an inadequate network. Insurers should bear the entire responsibility of ensuring patient access outside what is available in the network.

Issue 4: Benchmarking

We appreciate the fact that S.B. 1264 calls for the use of a benchmarking database that is not affiliated with a health benefit plan issuer or administrator, a physician, a health care practitioner, or other healthcare provider. When it comes to rules governing the submission of information for the benchmarking database to determine the 80th percentile of billed charges of all physicians or healthcare providers who are not facilities and the 50th percentile of rates paid to participating providers who are not facilities, we recommend that Texas utilize the only database that has been identified to meet the standard set forth in the law: FAIR Health, Inc.

FAIR Health has the nation's largest unbiased collection of privately-billed medical claims data and geographically-organized healthcare cost information. This produces relevant, reliable, and regionally-specific cost information. That information will allow Texas to avoid using opaque insurer data – a practice that often leads to lawsuit-inducing data manipulation practices on the part of insurers – and protect its patients from being exposed to potential corruption.

It is imperative that TDI *not* allow politically-derived public payer rates to be included in the datasets that determine the 80th percentile of billed charges and 50th percentile of rates paid. For example, Medicare – which was conceived to provide reliable, quality care for seniors, disabled, and end-stage renal disease patients – is not an appropriate measurement of the vast range of services that physicians across all specialties provide and should not be included in the dataset. For that reason, we recommend that the definitions of the 80th percentile of billed charges and 50th percentile of rates paid must include the following language:

> *The 80th percentile of all commercial charges for the particular healthcare service performed by a healthcare professional in the same specialty and provided in the same geographical area as reported in the benchmarking database determined by the commissioner.*
>
> *The 50th percentile of all commercial rates paid for the particular healthcare service performed by a healthcare professional in the same specialty and provided in the same geographical area as reported in the benchmarking database determined by the commissioner.*

Referencing "the same specialty" is necessary within the definition to ensure that rates reflect only billed and allowed amounts for services provided by the specific subset of medical providers. Clinical experience and education vary among specialties even when similar CPT codes are submitted across specialties. Rates used to determine the above percentiles must only compare comparable providers, determined by specialty, in order to adequately reflect appropriate payment.

TSPS and ASPS recognize the tremendous progress that Texas has made on this policy issue and look forward to working with other stakeholders to assist TDI in implementing S.B. 1264. Thank you for your consideration of our comments. Please do not hesitate to contact Patrick Hermes, Director of Advocacy and Government Relations, at [redacted] or [redacted] with any questions or concerns.

Sincerely,

Alan Matarasso, MD, FACS
President, American Society of Plastic Surgeons

Alfred Antonetti, MD, FACS
President, Texas Society of Plastic Surgeons

July 15, 2019

Dear Commissioner Sullivan:

US Anesthesia Partners (USAP) is a single specialty physician group focused on delivering superior anesthesia services through a commitment to quality, excellence, safety, innovation, satisfaction, and leadership. USAP and our affiliated practices operate in nine states, and we employ over 950 physician anesthesiologists in the state of Texas. We sincerely appreciate the opportunity to provide comments to the Texas Department of Insurance regarding SB 1264 in advance of the TDI stakeholder meeting scheduled for July 29, 2019 in Austin.

Questions from TDI are included in italics below, with our responses following.

Issue 1: Nonemergency Exemption

A consumer may 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?*
- *What specific information must the disclosure include to ensure consumers understand the potential out-of-pocket cost for the service?*
- *What rules should TDI consider to prevent consumers from getting disclosures when they may be under duress?*

1.1 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?

For nonemergency out-of-network care, notice should be provided prior to the patient's receiving a service that may result in a balance bill. Given the broad range of nonemergency services a patient may receive, some of which by their nature may enable different notification timelines (*e.g.*, obstetrics, cosmetic surgery, important diagnostic tests, and other elective procedures), a specific one-size-fits all timeline would not be appropriate.

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

An optional model disclosure form approved by the TDI, which providers may use to document a patient's agreement to be responsible for the costs for the procedure (including out-of-network costs),

would be appropriate. It is key that individual health care providers and specialties retain flexibility to create their own forms as needed. Any disclosure form, whether a TDI form or a form developed by a provider, would be received and agreed to by the patient prior to the medical procedure. The form should state clearly that final actual costs may vary from projected costs based on the actual aspects of the procedure as completed.

Specific information for the form should include projected potential costs for the patient, and/or the formula by which such costs will be calculated. The projected cost may consist of a formula where appropriate (*e.g.*, time units * provider rate for an aspect of the care provided, where the time for a procedure may vary considerably depending on complexity and other factors). In some specialties, such as anesthesia, the formula by which services are billed takes into account a base unit related to type of procedure, a unit based on the health and condition of the patient, and a time unit. It would be appropriate to share a formula with the patient in advance, and to share rates to the extent that the payer has provided sufficient information to determine the applicable rates, but it could be impractical to provide a final estimated cost with so many variables yet to be determined prior to the procedure.

For example, a particular type of surgery may vary in time based on factors outside of the provider's control, and the form should allow for such ordinary variations in its calculations. Any model disclosure form approved by the TDI should include some flexibility in its fields so that different specialty providers, such as anesthesiologists, may include the appropriate formula for the specialized care they provide. This approach will enable patients to receive meaningful estimates of projected costs, while permitting providers to calculate exact costs once the necessary information, such as time units, becomes available. Finally, the model disclosure form should clearly outline which specific services it addresses, along with a clear statement regarding what it does not include, if applicable.

In addition, to enable advance notice to patients when a provider is not in-network, health plans must be required to maintain current and accurate directories of in-network providers, and health plans must communicate this information to patients and providers in a regular and standardized format. If a provider does not make a required disclosure to a patient because a health plan's in-network directory is inaccurate or out of date, the health plan rather than the provider should be responsible for any inaccurate information given to patients based on a provider's good faith use of a directory.

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

Patients seeking medical care often may be in distress related to physical, personal, financial, and other concerns. While the goal of preventing patient receipt of disclosures while under duress is laudable, as a practical matter, creating a new duress standard for nonemergency cases could create uncertainty and open another avenue for unnecessary and costly disputes between parties. Therefore, a new "duress" standard should not be created. However, providers will be responsible to provide the relevant out-of-network cost disclosures to patients in advance of the patient's final decision to receive a medical procedure or treatment.

TDI should consider rules requiring written disclosures outlining the definition of emergency and nonemergency services on the disclosure document. A written reminder to patients regarding their rights in the case of emergency treatment could be helpful, along with a statement that the treatment they are seeking has been deemed non-emergency in nature.

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?*
- *To what extent should the process provide each party with an opportunity to rebut the information another party submitted to an arbitrator?*
- *Are rules needed to address how and when the parties must notify TDI if they cannot agree on an arbitrator?*
- *Are rules needed to address fees and standards for arbitrators?*

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

We recommend consideration of the New York Independent Dispute Resolution Model, which was developed specifically to address resolution of surprise medical bills. See https://www.dfs.ny.gov/IDR for details, along with additional information provided below.

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

To keep the process simple and efficient, each party should be able to provide its own information to the arbitrator, but we do not foresee a lengthy process needed for a party to rebut the information provided by the other party. When an arbitrator has questions about a party's information, the arbitrator may direct follow up questions to such party. Under the New York model, which uses "baseball style" arbitration, the most likely outcome is that the arbitrator selects one of two proposed fees (either the provider's or the health plan's proposed fee) based on assessment of the information provided by both parties, along with reference to independent data and standards. There should be objective criteria that the arbitrator uses to evaluate the reasonableness of the proposed fees, such as reference to an independent, nonconflicted database of allowables and charges.

2.3 Are rules needed to address fees and standards for arbitrators?

Under the New York model, when the independent dispute resolution entity determines a provider's fee is reasonable, the health plan pays for the cost of dispute resolution. When the independent dispute resolution entity determines a health plan's fee is reasonable, the provider pays for the cost of dispute resolution. This approach encourages both parties to make reasonable fee proposals and to resolve potential payment disputes without outside assistance.

Equal splitting of arbitrator fees by the parties, as outlined in SB 1264, with the ability for a provider to bring multiple fee disputes with a health plan to a single dispute resolution review, along with clear limits on arbitrator fees, will help ensure that small or solo providers retain the ability to dispute payment amounts in appropriate circumstances.

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

The parties should have the option of selecting and agreeing upon a qualified and impartial arbitrator, and if they cannot agree on one within the required timeframe, then the TDI will assign a nonconflicted arbitrator within a specified timeframe.

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.

3. 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?

We do not propose changes to TDI rules for access plans at this time. We appreciate TDI's commitment to and enforcement of adequate networks, and we encourage increased ability to review network adequacy and take appropriate action to protect patients from increased deductibles, copays, and cost sharing in general.

Issue 4: Benchmarking

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

4. 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."

An independent, nonconflicted database is necessary, and all health plans should be required to submit all of their Texas claims data to the applicable database regularly to ensure accuracy and fairness (vs. health plan selection of an unrepresentative sample that is artificially low in its payments to providers, for example). As outlined in SB 1264, the organization maintaining the database must not be affiliated with a health plan issuer or administrator, a physician, a health care provider, a health care practitioner, or have any other conflict of interest. Comprehensive information is necessary to ensure fair calculations and assessment of appropriate reimbursement for out-of-network services. The benchmarking database should include data from commercial insurance plans and self-insured plans and must exclude government plans from any benchmarking analysis.

SB 1264 requires that the benchmarking database contain the information necessary to calculate the relevant billed charges and rates paid within specific geographic regions or geozip areas, and it further defines "geozip area" as "an area that includes all zip codes with identical first three digits." We do not propose a different definition of "region", as the "geozip area" definition is clear in SB 1264, and the "geozip area" should be used as outlined in SB 1264.

The FAIR Health database has been used successfully in New York, and so long as health plans are required to submit the relevant information to FAIR Health for Texas, this resource could work for Texas as well. See https://www.fairhealth.org/. According to its webpage at https://www.fairhealth.org/data, FAIR Health includes data from over 28 billion privately billed medical and dental procedures, for over 150 million privately insured individuals, and covering 493 geozip regions.

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.

Written Documentation of Teleconference Settlement Offers: Section 1467.084(d) states that all parties must participate in an informal settlement teleconference prior to arbitration. Further, Section 1467.083 states that an arbitrator's determination must take into account "an offer made during the informal settlement teleconference required under Section 1467.084(d)". We recommend that TDI adopt a rule that requires written confirmation of each party's final offer from the informal settlement teleconference so that such offers may be verified and considered if the matter proceeds to arbitration.

Definition of "Usual and Customary Rate": SB 1264 states that initial payments to providers will be made at the usual and customary rate or at an agreed rate. SB 1264 also amends Section 1551.003 of the Insurance Code, Section 1575.002 of the Insurance Code, and Section 1579.002 of the Insurance Code, adding this new definition for those limited sections (and not for any other sections): "'Usual and customary rate' means the relevant allowable amount as described by the applicable master benefit plan document or policy."

We recommend that TDI adopt rules defining "usual and customary rate" across other sections in line with the historical definition of the term and continue the requirement that such "usual and customary rate" accounts for regional variations in cost, remains commercially driven, and reflects current market rates.

Thank you again for the opportunity to share our comments on SB 1264 in advance of the stakeholder meeting scheduled for July 29, 2019, and we appreciate your leadership on this important issue.

Sincerely,

US Anesthesia Partners