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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,

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