SUBCHAPTER OO. DISCLOSURES BY OUT-OF-NETWORK PROVIDERS
28 TAC §§21.4901 - 21.4904

INTRODUCTION. The Commissioner of Insurance adopts new 28 Texas Administrative Code (TAC) §§21.4901 - 21.4904, concerning disclosures by out-of-network providers. The new sections are adopted with changes to the proposed text published in the January 10, 2020, issue of the *Texas Register* (45 TexReg 268). The department adopts §21.4902 and §21.4904 without changes to the proposed text. The department revises §21.4901 and §21.4903 to correct punctuation for consistency with agency style, and the department also revises §21.4903 in response to public comments.

REASONED JUSTIFICATION. The new sections are necessary to implement exceptions to balance billing prohibitions in Insurance Code §§1271.157, 1271.158, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111, as enacted by Senate Bill 1264, 86th Legislature, Regular Session (2019).

A hearing was held on February 4, 2020.

The new rules interpret and implement SB 1264, which prohibits balance billing for certain health benefit claims under certain health benefit plans; provides exceptions to balance billing prohibitions; and authorizes an independent dispute resolution process for claim disputes between certain out-of-network providers and health benefit plan issuers and administrators.

SB 1264's balance billing protections generally apply to enrollees of health benefit plans offered by insurers and health maintenance organizations that the department regulates, as well as to the Texas Employees Group, the Texas Public School Employees Group, and the Texas School Employees Uniform Group. The changes to law made by the

bill apply to health care and medical services or supplies provided on or after January 1, 2020.

The new rules implement the exceptions to balance billing prohibitions found in Insurance Code §§1271.157, 1271.158, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111. The exceptions to balance billing prohibitions are only applicable in nonemergencies when a health benefit plan enrollee elects to receive covered health care or medical services or supplies from a facility-based provider that is not a participating provider for a health benefit plan, if the service or supply is provided at a health care facility that is a participating provider; or from a diagnostic imaging provider or laboratory service provider that is not a participating provider for a health benefit plan, if the service or supply is provided in connection with a health care or medical service or supply provided by a participating provider.

For many consumers, a surprise balance bill can be financially ruinous, which could dissuade some consumers from seeking necessary or advisable medical care. To protect consumers, SB 1264 prohibits many out-of-network providers from balance billing patients except in a very narrow set of circumstances. The proposed rules are necessary to prevent unscrupulous providers from exploiting the law's narrow exceptions to the balance billing prohibition, which would negatively affect the health and financial welfare of consumers. Without the new rules, a provider could demand that a patient sign away his or her balance billing protections mere moments before the patient receives surgery or some other medical care. Furthermore, without the new rule, the provider could slip an inconspicuous SB 1264 notice among a number of other forms that the enrollee must review before the procedure. Patients could be forced to make tough financial and health-related decisions in a vulnerable state, potentially without even knowing the balance billing protections they would be waiving. And if a patient hesitates or refuses to waive

their balance billing protections shortly before the procedure, there could be significant health consequences if treatment is delayed or refused because of arguments over billing between patient and provider.

On December 18, 2019, the department adopted 28 TAC §§21.4901 - 21.4904 under emergency rulemaking procedures, to be effective on January 1, 2020. The emergency rules will be withdrawn at the time these rules become effective.

New §21.4901 addresses the purpose and applicability of new Subchapter OO. The department makes a change to §21.4901 as proposed to remove the hyphen from the word "non-emergency," for consistency with agency style.

New §21.4902 provides that words and terms defined in Insurance Code Chapter 1467 have the same meaning when used in Subchapter OO, unless the context clearly indicates otherwise.

New §21.4903 clarifies that, for purposes of the exceptions to the balance billing prohibitions, an enrollee's election is only valid if the enrollee has a meaningful choice between an in-network provider and an out-of-network provider, the enrollee was not coerced by another provider or their health benefit plan into selecting the out-of-network provider, and the enrollee signs a notice and disclosure statement at least 10 business days before the service or supply is provided acknowledging that the enrollee may be liable for a balance bill and chooses to proceed with the service or supply anyway. Only an out-of-network provider that chooses to balance bill an enrollee is required to provide a notice and disclosure statement to the enrollee. The out-of-network provider may choose to participate in SB 1264's claim dispute resolution process instead of balance billing an enrollee.

New §21.4903 also adopts by reference the notice and disclosure statement that must be filled out by the out-of-network provider and given to the enrollee if the provider chooses to balance bill.

The proposed text in §21.4903 was changed in the adoption order in response to comments.

A change is made to §21.4903(a) to refer to an enrollee's "health benefit plan" instead of "health care plan." The department notes that SB 1264 uses both "health care plan" and "health benefit plan" in its provisions. Nevertheless, the department agrees to make the suggested change. However, this change in terms is not substantive and does not alter the scope or application of the rule.

The department makes a change to §21.4903(b). The department clarifies that legal representatives or guardians may make an election on behalf of an enrollee. The department adds "An enrollee's legal representative or guardian may elect on behalf of an enrollee" to the text of subsection (b).

The department also makes changes to §21.4903(d). The changes are made in part to allow for a provider's agent or assignee to maintain a copy of the notice and disclosure statement. This flexibility will help providers comply with the rule, for those providers that would rather delegate that responsibility. In addition, the department clarifies that the copy of the notice and disclosure statement must only be maintained if the medical service or supply is provided and a balance bill is sent. There is no need to maintain records when the underlying purpose is no longer necessary. The department also makes a change to state that the provider must provide the enrollee with a copy of the signed notice and disclosure statement on the same date the statement is received by the provider.

The department makes a change to §21.4903(f). The change clarifies when the dispute resolution procedures under Insurance Code Chapter 1467 and 28 TAC Chapter 21, Subchapter PP apply. The change provides an exception to the subsection's prohibition on participating in the dispute resolution processes if the election is defective or rescinded.

The department also makes changes to §21.4903(b) and (c) to remove the hyphen from the word "non-emergency," for consistency with agency style.

New §21.4904 requires health benefit plans to help their enrollees determine their financial responsibility for a service or supply for which a notice and disclosure statement has been provided, consistent with Insurance Code §1661.002.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received 103 written comments and six oral comments. Commenters in support of the proposal were: AARP, Center for Public Policy Priorities, and Office of Public Insurance Counsel. Commenters in support of the proposal with changes were: Texas Association of Health Plans, Texas Hospital Association, and Texas Public Policy Foundation. Commenters against the proposal were: 94 individuals; American College of Obstetricians and Gynecologists, District XI; American College of Physicians Services, Texas Chapter; Association of American Physicians and Surgeons, Inc.; Texas Medical Association; Texas Society for Gastroenterology and Endoscopy; and Texas Society of Pathologists.

Comments on the rule generally

Comment: Two commenters state that they strongly support proposed 28 TAC §§21.4901 – 21.4904 and state that it is consistent with the language and intent of SB 1264 and is necessary to protect Texas consumers.

One commenter states that it strongly supports the consumer protections in the proposed rules.

One commenter extends its support to the department's efforts and states that the rules are necessary to clarify that the nonemergency exception from the balance billing protections in SB 1264 is only permitted when the consumer has a choice between in-network and out-of-network providers and is afforded adequate time to understand the financial implications of their decision.

Agency Response: The department appreciates the support.

Comment: Many commenters state that the proposed rules contradict the principles of limited government and protection of individual rights in the Texas and U.S. Constitutions. One commenter states that the proposed rules protect third-party interests and are not in the best interests of the good practice of medicine or quality patient care.

Agency Response: The department notes that the commenters failed to specify which provisions of the U.S. or Texas Constitutions they believe are inconsistent with the proposed rules. Nevertheless, the department does not agree that the proposed rules violate either the federal or state constitutions. The department proposed the rule to interpret and implement SB 1264, including its limited exceptions to the balance billing prohibition. SB 1264 and the proposed rules serve an important consumer protection function, as surprise balance bills can be financially ruinous for many consumers. The proposed rules do not unreasonably intrude on the doctor–patient relationship, because the rules only apply when an out-of-network provider chooses to balance bill a patient.

An out-of-network provider that chooses to participate in SB 1264's claim dispute resolution process instead of balance billing a patient is not subject to the proposed rule requirements.

Comment on §21.4901.

Comment: Several commenters state that the department has insufficient statutory authority to adopt the proposed rules. The commenters state that Insurance Code §§36.001, 752.0003(c), and 1467.003 do not authorize the department to adopt the rule proposal. The commenters also assert that the department's limited jurisdiction does not include prohibitions on balance billing and the disclosure exceptions.

Agency Response: The department disagrees that it lacks statutory authority to adopt the proposed rules or that it has exceeded its jurisdiction.

Insurance Code §36.001 provides authority for the Commissioner to adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state. Insurance Code §31.002(3) imposes a duty on the department to "ensure that the Insurance Code and other laws regarding insurance and insurance companies are executed...." Therefore, for purposes of determining the department's authority, it is significant that all provisions of SB 1264, including the balance billing prohibitions, were codified in the Insurance Code.

Enforcement of the balance billing prohibition is governed by Chapter 752 of the Insurance Code. Section 752.0003(c) states that an appropriate regulatory agency "or the commissioner may adopt rules as necessary to implement this section." The department has exercised its rulemaking authority to interpret and implement SB 1264.

Insurance Code §1467.003 mandates that the department adopt rules as necessary to implement its powers and duties under Chapter 1467, which governs out-of-network

claim dispute resolution. The proposed rules are related to the dispute resolution processes created by Chapter 1467. The proposed written notice and disclosure procedure and form are inextricably linked to the application of the dispute resolution processes in Chapter 1467 and the rules that implement that chapter in 28 TAC Chapter 21, Subchapter PP. Though the proposed rules and Subchapter PP are in different subchapters, they are part of a coherent regulatory framework of balance billing consumer protections. Proposed section 21.4903(f) relates to Insurance Code Chapter 1467 and makes explicit the connection between the subchapters.

Comment: One commenter requests that the purpose and applicability of the proposed rules be clarified to not include direct care models of providing health care because a direct care provider or facility does not submit out-of-network claims to a health benefit plan. Another commenter asks whether the proposed rules would apply to providers that offer patients up-front pricing for health care services. The commenter notes that these patients already have an understanding that they will be paying out-of-network costs but want the procedure performed at an in-network facility that is covered by their plan.

Agency Response: The department declines to make a change. The applicability of the proposed rules is based on and is consistent with the applicability of SB 1264's balance billing prohibitions to out-of-network facility-based providers, diagnostic imaging providers, and laboratory service providers. SB 1264 clearly defines "facility-based provider," "diagnostic imaging provider," and "laboratory service provider."

Consistent with Insurance Code §752.0003, regulatory agencies that license, certify, or otherwise authorize providers have authority to discipline their respective providers for violating a law that prohibits the provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, or deductible. The

department will coordinate with other regulatory agencies and will refer complaints about balance billing appropriately. The appropriate regulatory agency will determine the appropriate sanctions, if any, for a violation of the statute or the rules. The department has communicated with other state agencies and will continue to work with them to implement SB 1264. The department will closely monitor implementation and be ready to provide additional guidance, as needed.

Comments on §21.4903.

Comment: Several commenters note that the term "enrollee" is used throughout proposed §21.4903 and the form. The commenters suggest that the notice and disclosure form be revised to permit a guardian or legal representative of the patient to sign the form.

Agency Response: The department agrees with the commenters and has revised the proposed text by amending §21.4903(b) to clarify that an enrollee's legal representative or guardian may elect on behalf of an enrollee.

Comment: Several commenters recommend that the term "health care plan" be replaced with "health benefit plan."

Agency Response: The department notes that SB 1264 uses both "health care plan" and "health benefit plan" in its provisions. Nevertheless, the department agrees to make the suggested change. However, this change in terms is not substantive and does not alter the scope or application of the rule.

Comment on: Several commenters recommend deleting §21.4903(b)(1). The commenters state that the proposed requirement limits the exception to the balance billing prohibition

beyond what the Legislature intended. The commenters also oppose §21.4903(b)(1) because it would make satisfaction of the requirement dependent on a third party that is out of the provider's control. In addition, commenters state that the requirement is vague, overbroad, too subjective, and does not provide enough guidance. Further, the commenters state that if an enrollee is assigned an out-of-network provider, but is offered a choice, the assigned out-of-network provider should be able to use the waiver.

One commenter states that it supports the provisions of proposed §21.4903(b), and states that the provisions ensure that an actual election by the patient, within the meaning of SB 1264, has taken place.

One commenter supports the proposed rule because it allows providers to avoid the consumer protections of SB 1264 and balance bill only in the limited situation where they have given their patient all the information needed to make an informed decision and the patient has actively chosen to see that out-of-network provider.

Agency Response: The department disagrees that proposed §21.4903(b)(1) is inconsistent with SB 1264 and exceeds the department's statutory authority. The proposed rule interprets and implements the consumer protections imbedded in SB 1264 and is consistent with the statute. As stated in the Author's/Sponsor's Statement of Intent, SB 1264 "prevents consumers from receiving surprise medical bills so that in situations where the consumer has no choice over who provides their care, they cannot be surprise-billed." Senate Research Center, Bill Analysis, Tex. S.B. 1264, 86th Leg., R.S. (2019). Proposed §21.4903(b)(1) implements SB 1264 by clarifying that if an out-of-network provider wants to balance bill a consumer, that consumer must have a meaningful choice between an in-network provider and the out-of-network provider. As other commenters recognize, proposed §21.4903(b)(1) ensures that an election occurs, not merely an assignment.

The department acknowledges that individual providers may not have control over the assignment of providers to a particular enrollee. However, in circumstances where enrollee election is not feasible, providers are still entitled to payment under SB 1264's default arrangement. This includes payment at the usual and customary rate or at an agreed-on rate and an option to utilize alternate dispute resolution processes under Insurance Code Chapter 1467 and the rules adopted in 28 TAC Chapter 21, Subchapter PP. The statutory and regulatory framework operates to make the exceptions to the balance billing prohibition not the presumed operation, but the narrowly available option.

Comment: Several commenters state that the term "coerced," as used in proposed §21.4903(b)(2), is vague and overbroad. The commenters also object to the proposed language because it provides that an out-of-network provider's use of the exception can be invalidated by someone else's coercive conduct—and potentially subjecting a provider to discipline because of someone else's conduct is unfair and exceeds the department's authority. The commenters state that the provision is a new condition that was not authorized by the Legislature. In addition, the commenters state that the language could put a provider in the position of being unable to either balance bill or access the dispute resolution procedures established under Insurance Code Chapter 1467.

Agency Response: The department disagrees that the text of proposed §21.4903(b)(2) is impermissibly vague or overbroad. *See CISPES (Comm. in Solidarity with People of El Salvador) v. FBI*, 77 F.2d 468, 475-76 (5th Cir. 1985) (addressing whether the term "coerce," as used in a federal statute, is vague or overbroad). An administrative rule need not define all the terms used in the rule, particularly when the term in question has a commonly understood definition. *See Tex. Mut. Ins. Co. v. Vista Cmty. Med. Ctr.*, 275 S.W.3d 538, 554 (Tex. App.–Austin 2008, pet. denied). In this context, to "'coerce' means to 'persuade (an

unwilling person) to do something by using force or threats.'" Tex. Att'y Gen. Op. No. GA-949 (2012) (quoting New Oxford American Dictionary). Furthermore, the rule provides additional clarity as to the usage of the term, stating that "[a] provider engages in coercion if the provider charges or attempts to charge a nonrefundable fee, deposit, or cancellation fee for the service or supply prior to the enrollee's election." Both the plain meaning of the term and its usage in the context of §21.4903(b)(2) demonstrate that it is not impermissibly vague or overbroad.

The department also disagrees that proposed §21.4903(b)(2) is inconsistent with SB 1264 and exceeds the department's statutory authority. The proposed rule interprets and implements the consumer protections imbedded in SB 1264 and is consistent with the statute. The rule simply recognizes that a valid election or choice must be free of coercion. That principal is recognized in other settings involving elections. *See, e.g., Union Mfg. Co. v. NLRB*, 221 F.2d 532, 540 (D.C. Cir. 1955) (Under the National Labor Relations Act, a "'valid' election is one free from fraud, from restraint or from coercion of employees in the exercise of their rights.").

The commenters are also concerned that, due to the proposed rule, a provider could be put in the position of being unable to either balance bill a patient or participate in SB 1264's dispute resolution process. The proffered scenario assumes that the enrollee can successfully demonstrate that the notice and disclosure was entered into coercively. This would be a question of fact that the provider could rebut, as with other contractual disputes. In response to other comments, the department made changes to §21.4903(f) to clarify that in instances where coercion took place, voiding the election, then the claim may be eligible to participate in dispute resolution under Insurance Code Chapter 1467 and 28 TAC Chapter 21, Subchapter PP. Therefore, the department does not believe a change to the proposed rule is warranted in response to the commenters' concern.

Comment: Several commenters oppose the language in §21.4903(b)(3) that requires the provider to obtain the enrollee's written consent. The commenters state that the provision is a new condition that was not authorized by the Legislature. The commenters also recommend that proposed §21.4903(b)(3) be amended to allow the enrollee's legal representative or guardian to provide the required consent.

Agency Response: The department agrees that an enrollee's legal representative or guardian should be permitted to provide the written consent required by the rule. In response to comment, the department amends §21.4903(b) accordingly.

The department does not agree that proposed §21.4903(b)(3) is inconsistent with SB 1264 and exceeds the department's statutory authority. The proposed rule interprets and implements the consumer protections imbedded in SB 1264 and is consistent with the statute. SB 1264 requires that an enrollee make an election in writing, and the proposed rule simply clarifies that such an election is manifested through the enrollee's written consent.

Comment: Several commenters have concerns with the requirement that out-of-network providers provide the notice and disclosure statement before scheduling a medical service or supply. The commenters believe that this requirement is not authorized by statute, and state that the requirement imposes operational challenges that make the use of the exception almost impossible for certain provider types. If the department moves forward with the scheduling requirement, the commenters recommend that it be substituted with language that the notice and disclosure statement must be provided to the enrollee or the enrollee's legal representative or guardian no later than three business days after the scheduling of the nonemergency service or supply. According to the commenters, this

shorter time frame would better reflect how services are delivered by indirect access providers.

Two commenters support each of the provisions in §21.4903(c) and state that they work together to ensure that patients can freely make an election without feeling coerced.

Agency Response: The department does not agree that proposed §21.4903(c) is inconsistent with SB 1264 and exceeds the department's statutory authority. The proposed rule interprets and implements the consumer protections imbedded in SB 1264 and is consistent with the statute. SB 1264 requires certain out-of-network providers to provide a complete written disclosure about a medical service or supply in order to balance bill the patient for that service or supply. The department believes that, for the written disclosure requirement to be an effective consumer protection tool, the disclosure must be provided to the patient before scheduling the service or supply. Nevertheless, the proposed rule does not require the notice and disclosure statement to be provided at a separate office visit from the scheduling. The provision simply requires that the notice and disclosure statement, and the important consumer information and cost estimate, be provided before scheduling the service or supply. Provision of the notice and disclosure statement and scheduling of the service or supply could occur consecutively at the same office visit.

The department recognizes that indirect access providers may have more difficulties providing the notice and disclosure statement in the timeframes required by the rule. However, SB 1264 requires an enrollee election, and it does not provide lesser consumer protections because those protections may be inconvenient. In circumstances where an enrollee election fails to satisfy the requirements of the rule, providers are still entitled to payment under the default statutory arrangement. This includes payment at the usual and customary rate or at an agreed rate. Additionally, the provider may be able

to seek alternate dispute resolution processes under Insurance Code Chapter 1467 and the rules adopted in 28 TAC Chapter 21, Subchapter PP. The statutory framework operates to make the use of the notice and disclosure statement not the presumed operation, but the narrowly available option.

Comment: Many commenters state that requiring a patient to wait at least 10 business days to receive care from an out-of-network provider — on mutually agreeable terms — is potentially dangerous and contrary to the wording and intent of SB 1264. One commenter states that requiring a patient to wait 10 business days to receive assistance for medical problems will magnify those problems.

Several commenters state that requiring delay of treatment is not just inconvenient, but is also potentially dangerous and discriminates against patients who might prefer a provider who does not contract with a third-party payer.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department notes that the proposed rule does not require an out-of-network provider to wait 10 business days before providing a medical service or supply. Rather, the signed the notice and disclosure statement are required at least 10 business days before the date of the service or supply only if the provider chooses to balance bill the patient. If the provider is willing to accept a reasonable payment for the service or supply through SB 1264's independent dispute resolution process instead of balance billing the patient, the service or supply can be scheduled at any time that is agreeable to the patient and provider. Any delays in care will be the result of providers' billing choices and not the proposed rule.

The department also does not agree that proposed §21.4903(c) is inconsistent with SB 1264 and exceeds the department's statutory authority. The proposed rule interprets and implements the consumer protections imbedded in SB 1264 and is consistent with the statute. To protect consumers, SB 1264 prohibits many out-of-network providers from balance billing patients except in a very narrow set of circumstances. The new rules are necessary to prevent providers from exploiting the law's narrow exceptions to the balance billing prohibition, which, if allowed, would exacerbate the balance billing concerns that led to the passage of SB 1264. Without the new rules, particularly proposed §21.4903(c), a provider could demand that a patient sign away his or her balance billing protections mere moments before the patient receives surgery or some other medical care. Furthermore, without the new rules, the provider could slip an inconspicuous SB 1264 notice amongst several other forms that the enrollee must review prior to the procedure. Patients could be forced to make tough financial and health-related decisions in an extremely vulnerable state, potentially without even knowing the balance billing protections they would be waiving. And if a patient hesitates or refuses to waive their balance billing protections shortly before the procedure, there could be significant health consequences if treatment is delayed or refused because of arguments over billing between patient and provider.

Comment: One commenter asks who bears the liability in the event a nonemergent medial issue becomes life-threatening during a 10-business day wait.

Agency Response: The department does not determine tortious liability. Liability is set by law and the application of that law is fact specific. The department notes, however, that the proposed rule does not require an out-of-network provider to wait 10 business days before providing a medical service or supply. Rather, the signed notice and disclosure

statement are required at least 10 business days before the date of the service or supply only if the provider chooses to balance bill the patient. Any delays in care will be the result of the providers' billing choices and not the proposed rule. Furthermore, under SB 1264 the disclosure and notice requirements imposed by these rules are not applicable to emergency care or supplies.

Comment: One commenter asks for the department's rationale for choosing a 10-business day timeframe.

Agency Response: The department's reason for choosing 10 business days is so that the enrollee has adequate time to consider the potential financial impact of his or her decision. In addition, the timeframe provides an enrollee the opportunity to contact their health benefit plan or administrator and request assistance to improve the accuracy of the cost estimate. The time also may allow an enrollee to consider alternatives to the out-of-network provider.

Comment: Several commenters express concern about the 10-business day requirement in proposed §21.4903(c). The commenters state that the one-size-fits-all timeframe is arbitrary, contrary to the plain language of the statute, and presents challenges to patients and providers alike. The commenters note that the delay is not required for consent to the procedure itself and is longer than timeframes advocated by stakeholders in the context of the department's stakeholder process. The commenters highlight certain scenarios where the 10-day requirement may affect health-care practices. For example, where a patient wants to pick an out-of-network provider but have the service performed at an in-network facility and wants to have the service performed sooner than 10 business days. Another scenario the commenters discuss is for urgent care issues, where the rule

would apply even if the patient would like to be treated and be willing to pay the balance bill without waiting for the requisite time period.

The commenters state that if the department is unwilling to remove the time requirement, they recommend lowering it to three business days with one business day for rescission. Additionally, the commenters recommend that if the department moves forward that it add the option to waive the 10-business day requirement, and another possible exception for urgent care scenarios.

Two commenters support the 10-business-day timeframe and state that it is reasonable and necessary to protect patients. First, it ensures that patients who need medical care urgently will not be placed under duress by a waiver. Second, it affords the patient time needed to make an informed election. They state that the timeframe needs to accommodate the ability of a patient to explore alternatives, including in-network alternatives, after learning through the notice and disclosure statement that some of their care will be out-of-network and cost more. The patient will need time to contact their health plan to both get firm costs for care outlined in the disclosure as well as to identify alternate in-network providers. The patient also may need to reach out to alternative providers to learn more or get an appointment. The timeframe also needs to accommodate a reasonable period during which a patient can rescind acceptance of the waiver, in the event that they are able to find alternate in-network providers.

One commenter recommends that the department not adopt a specific timeframe, because an excessive notice period could result in unnecessary delays in nonemergent care.

One commenter states that the form be provided in time for the consumer to make an informed decision on whether to proceed in getting out-of-network care. They state that the rule addresses this concern.

Agency Response: The department recognizes these concerns but does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. The department notes that requesting a waiver is entirely optional on the part of the provider or facility.

As other commenters recognize, the 10-business day timeframe provides an enrollee the opportunity to contact their health benefit plan or administrator and request assistance to improve the accuracy of the cost estimate. The time also may allow an enrollee to consider alternatives to the out-of-network provider.

The 10-business day requirement provides strong balance billing protection, consistent with the intent of SB 1264. A shorter timeframe or an enrollee waiver exception would erode the strong balance billing prohibitions created by the Legislature. SB 1264 prohibits many out-of-network providers from balance billing patients except in a very narrow set of circumstances. The statute provides new payment regulations to benefit out-of-network providers, including the possibility of dispute resolution. The department acknowledges the notice and disclosure procedures are not as simple or expedient as medical informed consent, but the framework of SB 1264 assumes that these waivers will not be the default billing scenario. There is a tradeoff between enrollee balance billing protection and status quo disruption, but SB 1264 requires a strong consideration of consumer protection.

Comment: Several commenters express concerns with the record retention requirement in proposed §21.4903(d). Some commenters state that the record retention requirement is not authorized by statute and that the department has no authority to impose it. Some commenters suggest that the rule be amended to allow the provider's agent or assignee to maintain and provide a copy of a signed and dated notice and disclosure statement.

The commenters also suggest that the proposed rule is overbroad because it could require a provider to maintain the record even if the provider does not perform the service or balance ball the enrollee. The commenters also have concerns that the proposed rule would require a provider to provide a copy of the signed notice and disclosure statement on the same date the statement is signed, even if the enrollee signs the statement but does not immediately provide it to the provider. The commenters also recommend language that clarifies that a provider's failure to maintain a copy of the notice and disclosure statement or to provide a copy to the enrollee does not disqualify a provider from eligibility for the balance billing exception.

Two commenters support §21.4903(d) and state that it is important that the provider both give a copy of the signed statement to the patient and retain a copy for long enough that all billing, payments, and any disputes would have been resolved.

Agency Response: The department agrees to revise the proposed rule in response to some of the comments. The department believes it is reasonable to permit a provider's agent or assignee to maintain a signed notice and disclosure statement, and the proposed language is amended accordingly.

The department also agrees with the commenters that a provider need not maintain a signed statement if the provider ultimately does not perform the medical service or supply or balance bill the enrollee. The proposed language is amended accordingly.

The department also agrees with the commenters to amend the proposed language to clarify that a provider must give the enrollee a copy of the signed statement on the same date the signed statement is provided to the provider by the enrollee.

The department does not agree that proposed §21.4903(d) exceeds the department's statutory authority. The proposed rule interprets and implements the

consumer protections imbedded in SB 1264 and is consistent with the statute. The existence of a signed statement is key to determining whether the balance billing prohibition was properly waived, thus it is proper to require providers to maintain that document for a reasonable period of time. The department further notes that the cost to maintain these documents is expected to be negligible. Providers already maintain patients' health and billings records, and the new notice and disclosure statement form may be stored with other documents commonly used by providers.

The department also declines to amend the proposed language to clarify the consequences to a provider for failing to maintain a copy of the notice and disclosure statement or provide a copy of the signed statement to the enrollee. The regulatory agency that licenses the provider is responsible for enforcing the proposed rules and determining sanctions or penalties where appropriate.

Comment on §21.4903(f): Several commenters note that a provider should be permitted to participate in SB 1264's dispute resolution process if the provider decides not to balance bill, receives an enrollee rescission, reschedules for a later date and does not balance bill, or realizes the form is defective. The commenters suggest revised language to amend §21.4903(f) and a new related §21.4903(g).

Two commenters state that they support §21.4903(f). They state that it ensures out-of-network providers use just one of the two available paths for payment in SB 1264.

Agency Response: The department agrees to revise the proposed rule in response to some of the comments. The department believes it is reasonable to permit a provider to participate in the dispute resolution processes described in Insurance Code Chapter 1467 if an enrollee rescinds a waiver or if the election was invalid because it does not meet the requirements of §21.4903(b). Changes to §21.4903(f) are made to provide clarification.

The department declines to allow a provider to receive a valid election under §21.4903 and then later unilaterally put it aside and pursue statutory dispute resolution. Once a waiver is agreed to, the enrollee has certain expectations. Allowing the retrospective unilateral waiver on the part of the provider might encourage providers to seek such waivers as a matter of routine practice. Additionally, existence of a waiver is a threshold question in the department's portal. The department anticipates contested waivers to be infrequent events. Allowing provider cancellation of a waiver already sought and obtained impedes the efficient implementation of the portal.

Comments on §21.4904. Two commenters state that proposed §21.4904 ensures health plans will help patients understand their costs outlined in the waiver.

Several commenters recommend that the adopted rule include an additional subsection to ensure that health benefit plan issuers and administrators are required to provide information similar to the Insurance Code §1661.002 requirement to provide information to enrollees in order to assist providers.

Agency Response: The department does not agree that changes to the proposed rule text are necessary and declines to revise the proposed rule. SB 1264 requires providers to provide a complete written disclosure to the enrollee, including specific mandates to disclose projected amounts for which the enrollee may be responsible and the circumstances under which the enrollee would be responsible for those amounts. The department recognizes that out-of-network providers may lack the ability to make precise predictions as to an enrollee's financial responsibility. However, the provider should be able to provide the likely billed charges. The department and other regulatory agencies enforcing SB 1264 have the discretion to consider the full context of what information an out-of-network has access to. The department anticipates that out-of-network providers

will make their best efforts to provide as much information as possible so that the enrollees may make an informed decision.

SB 1264 does not create a specific requirement for health benefit plans to provide out-of-network enrollee financial responsibility information to out-of-network providers, but the department expects that health benefit plans will coordinate with out-of-network providers in the interest of their enrollees.

Comments on the form

Comment: One commenter states that the form should be written in plain language for the consumer to make an informed decision on whether to proceed with out-of-network care despite the potential for balance billing.

Agency Response: The department agrees that plain language is important for the enrollee to make an informed decision, and it believes the proposed form uses plain language.

Comment: Several commenters recommend that the "you may need to pay" column be eliminated and replaced with a direction to seek an estimate of the health benefit plan issuer's or administrator's payment and coverage information. The commenters state that the requirement is neither appropriate nor feasible and could cause delays in care. In addition, the commenters ask the department to add an exception to the rules for a provider's good faith attempt if the department adopts the form as proposed.

One commenter also has concerns over the ability of an out-of-network provider to obtain information necessary for the form. The commenter urges an exemption for out-of-network physicians and their patients from the requirements to provide cost sharing information in situations where patients and physicians already have been making

mutually agreeable and mutually beneficial arrangements without the oversight of this new rule.

Agency Response: The department does not agree that changes to the proposed form are necessary and declines to revise the form. SB 1264 requires a complete written disclosure to the enrollee, including specific mandates to disclose projected amounts for which the enrollee may be responsible and the circumstances under which the enrollee would be responsible for those amounts. The department recognizes that out-of-network providers may lack the ability to make precise predictions as to an enrollee's financial responsibility. However, the provider should be able to provide the likely billed charges. The department and other regulatory agencies enforcing SB 1264 have the discretion to consider the full context of what information an out-of-network provider has access to. The department anticipates that out-of-network providers will make their best efforts to provide as much information as possible so that the enrollees may make an informed decision.

Comment: Several commenters recommend striking or modifying many portions of the notice and disclosure form. These changes include amending the form title, headings, and content. Alternative language is suggested.

Agency Response: The department does not agree that changes to the proposed form are necessary and declines to revise the form. As previously noted, the form was written in plain language so that it is easy to understand. The department believes that the potential financial consequences of an enrollee signing the form are substantial, and the form was drafted so that enrollees would know the legal protections they are waiving. The department believes that the changes proposed by the commenters would undercut the intent of the form.

The department does note that the proposed rules do not prohibit a provider from manually entering the required information in the form, provided that it is legible.

Comment: One commenter asks the department to remove the CPT code requirement in the waiver form. The commenter states that a clear description of the service should suffice.

Agency Response: The department declines to modify this portion of the form. However, the department acknowledges that CPT codes are the intellectual property of the American Medical Association, and that not every provider uses CPT codes, or they may use them only selectively. The department encourages supplying CPT codes where the provider can provide them so that the enrollee can provide the code to their health benefit plan for an explanation of potential costs. The regulatory agencies charged with enforcing the proposed rules can determine whether a provider has substantially complied with the rule requirements and SB 1264.

Other comments:

Comment: One commenter recommends that the proposed rules address submission of claims subject to SB 1264 to require an indication of whether or not a waiver has been obtained and to clarify that such information may constitute "information necessary for" the health plan to pay the claim for purposes of the timely payment provisions of SB 1264.

One commenter asks the department to consider how insurers could be better held accountable for providing enrollees seeking out-of-network care and their physicians timely access to the information they need to make informed choices.

Agency Response: The department declines to make a change. These concerns are outside the scope of the proposed rules because the proposed rules implement what is

required by SB 1264. Submission of claims is regulated by other provisions not amended by SB 1264. The department encourages health benefit plans to assist providers with supplying accurate cost estimates to enrollees.

Comment: One commenter suggested that the state pass a law to stop insurance companies from having network policies at all in Texas.

Agency Response: The department declines to make a change as the comment is outside the scope of the proposed rules and the department's authority.

STATUTORY AUTHORITY. The department adopts the new §§21.4901 - 21.4904 under Insurance Code §§36.001, 752.003(c), and 1467.003.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

Insurance Code §752.0003(c) authorizes the Commissioner to adopt rules as necessary to implement balance billing prohibitions and exceptions to those prohibitions outlined in Insurance Code §§1271.157, 1271.158, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111.

Insurance Code §1467.003 provides that the Commissioner may adopt rules as necessary to implement the Commissioner's powers and duties under Insurance Code Chapter 1467.

TEXT.

SUBCHAPTER OO. DISCLOSURES BY OUT-OF-NETWORK PROVIDERS
28 TAC §§21.4901 -21.4904

§21.4901. Purpose and Applicability.

(a) The purpose of this subchapter is to interpret and implement Insurance Code §§1271.157, 1271.158, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111; and Insurance Code Chapter 1467.

(b) Section 21.4903 of this title is only applicable to a covered nonemergency health care or medical service or supply provided by:

(1) a facility-based provider that is not a participating provider for a health benefit plan, if the service or supply is provided at a health care facility that is a participating provider; or

(2) a diagnostic imaging provider or laboratory service provider that is not a participating provider for a health benefit plan, if the service or supply is provided in connection with a health care or medical service or supply provided by a participating provider.

§21.4902. Definitions.

Words and terms defined in Insurance Code Chapter 1467 have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

§21.4903. Out-of-Network Notice and Disclosure Requirements.

(a) For purposes of this section a "balance bill" is a bill for an amount greater than an applicable copayment, coinsurance, and deductible under an enrollee's health benefit plan, as specified in Insurance Code §§1271.157(c), 1271.158(c), 1301.164(c), 1301.165(c), 1551.229(c), 1551.230(c), 1575.172(c), 1575.173(c), 1579.110(c), or 1579.111(c).

(b) An out-of-network provider may not balance bill an enrollee receiving a nonemergency health care or medical service or supply, and the enrollee does not have

financial responsibility for a balance bill, unless the enrollee elects to obtain the service or supply from the out-of-network provider knowing that the provider is out-of-network and the enrollee may be financially responsible for a balance bill. An enrollee's legal representative or guardian may elect on behalf of an enrollee. For purposes of this subsection, an enrollee elects to obtain a service or supply only if:

(1) the enrollee has a meaningful choice between a participating provider for a health benefit plan issuer or administrator and an out-of-network provider. No meaningful choice exists if an out-of-network provider was selected for or assigned to an enrollee by another provider or health benefit plan issuer or administrator;

(2) the enrollee is not coerced by a provider or health benefit plan issuer or administrator when making the election. A provider engages in coercion if the provider charges or attempts to charge a nonrefundable fee, deposit, or cancellation fee for the service or supply prior to the enrollee's election; and

(3) the out-of-network provider or the agent or assignee of the provider provides written notice and disclosure to the enrollee and obtains the enrollee's written consent, as specified in subsection (c) of this section.

(c) If an out-of-network provider elects to balance bill an enrollee, rather than participate in claim dispute resolution under Insurance Code Chapter 1467 and Subchapter PP of this title, the out-of-network provider or agent or assignee of the provider must provide the enrollee with the notice and disclosure statement specified in subsection (e) of this section prior to scheduling the nonemergency health care or medical service or supply. To be effective, the notice and disclosure statement must be signed and dated by the enrollee no less than 10 business days before the date the service or supply is performed or provided. The enrollee may rescind acceptance within five business days

from the date the notice and disclosure statement was signed, as explained in the notice and disclosure statement form.

(d) Each out-of-network provider, or the provider's agent or assignee, must maintain a copy of the notice and disclosure statement, signed and dated by the enrollee, for four years if the medical service or supply is provided and a balance bill is sent to the enrollee. The provider must provide the enrollee with a copy of the signed notice and disclosure statement on the same date the statement is received by the provider.

(e) The department adopts by reference Form AH025 as the notice and disclosure statement to be used under this section. The notice and disclosure statement may not be modified, including its format or font size, and must be presented to an enrollee as a stand-alone document and not incorporated into any other document. The form is available from the department by accessing its website at www.tdi.texas.gov/forms.

(f) A provider who seeks and obtains an enrollee's signature on a notice and disclosure statement under this section is not eligible to participate in claim dispute resolution under Insurance Code Chapter 1467 and Subchapter PP of this title. This subsection does not apply if the election is defective as described by subsection (b) of this section or rescinded by the enrollee under subsection (c) of this section.

§21.4904. Health Benefit Plan Issuer and Administrator Responsibility.

Consistent with Insurance Code §1661.002, a health benefit plan issuer or administrator must assist an enrollee with evaluating the enrollee's financial responsibility for a health care or medical service or supply based on the information in the notice and disclosure statement provided to the enrollee under §21.4903 of this title.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on 6/5/2020.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts new 28 TAC §§21.4901 - 21.4904.

DocuSigned by:
Kent Sullivan
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Kent C. Sullivan
Commissioner of Insurance

Commissioner's Order No. **2020-6358**