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

INTRODUCTION. The Texas Department of Insurance proposes new 28 TAC §§21.4901 - 21.4904, concerning disclosures by out-of-network providers. The new rules 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).

EXPLANATION. 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 non-emergencies 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 in turn will likely dissuade some consumers from seeking necessary or advisable medical care in the future. 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 impact 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 amongst a number of 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.

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 proposed rules become effective.

New §21.4901 addresses the purpose and applicability of new Subchapter OO.

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 ten 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.

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.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Nancy Clark, chief of staff, has determined that during each year of the first five years the proposed new rules are in effect, there will be no fiscal impact on state and local governments as a result of enforcing or administering the proposed rules, other than that imposed by statute. This determination was made because the proposed rules do not add to or decrease state

revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed rules. The cost analysis in the Public Benefit and Cost Note section of this proposal may apply to providers, such as hospitals, that are owned by state or local governments. Pursuant to Insurance Code §752.003, other state agencies may be involved in enforcing balance billing prohibitions.

Ms. Clark does not anticipate any effect on local employment or the local economy as a result of the proposed rules.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new rules are in effect, Ms. Clark expects that administering the proposed new rules will have the public benefit of implementing Insurance Code §§1271.157, 1271.158, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111, and Chapter 1467, by clarifying when exceptions to balance billing prohibitions are permitted and by prescribing the required notice and disclosure statement an out-of-network provider can optionally provide to an enrollee. The proposed rules will also help protect many health care patients from surprise balance bills, consistent with the intent of SB 1264.

Ms. Clark expects that the proposed new rules may increase the administrative costs associated with the maintenance of signed notice and disclosure statements for providers who choose to balance bill and that are subject to the rules. 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.

Providers who choose to balance bill and who are subject to the proposed rules may experience increased administrative costs associated with providing the notice and disclosure statement to an enrollee. However, the obligation to provide a notice and disclosure statement to an enrollee is based in statute. Thus, any increased administrative

costs are a direct result of SB 1264, not the proposed rules. Furthermore, the obligation to provide the notice and disclosure statement is only applicable if the provider chooses to balance bill an enrollee.

Providers may also experience a financial impact related to final claim reimbursement if prohibited from balance billing. However, because the balance billing prohibitions were enacted in SB 1264, any financial impact is due to statute and not these proposed rules. Furthermore, providers may choose to balance bill enrollees or participate in SB 1264's dispute resolution process based on their own estimate of final reimbursement.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS.

The department has determined that the proposed new rules may have an adverse economic effect on small or micro businesses. However, the department does not expect the minimal costs associated with the proposed rules to have a disproportionate economic impact on small or micro businesses. The department has determined that the proposed new rules will not have an adverse economic impact on rural communities. The cost analysis in the Public Benefit and Cost Note section of this proposal also applies to these small and micro businesses and rural communities. The department estimates that the proposed new rules have the potential to affect thousands of hospitals, other health facilities, individual physicians, surgical assistants, and other health providers that qualify as small or micro businesses, but only if the provider chooses to balance bill and is subject to the proposed rules. There are at least 43,000 licensed physicians in Texas, and the Comptroller estimates that about 14,000 may be small employers. The Comptroller also estimates that there may be about 30,000 ambulatory health care service employers, 500 medical and diagnostic laboratories, and 160 hospitals that are small employers.

The department considered the following alternatives to minimize any adverse impact on small or micro businesses while still accomplishing the proposal's objectives:

(1) The department considered not proposing the new rules, but ultimately rejected this option in order to ensure SB 1264's balance billing protections are properly implemented for the protection of consumers. The new rules are necessary to prevent unscrupulous providers from exploiting the law's narrow exceptions to the balance billing prohibition, which would cause consumer harm. 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 amongst a number of 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. To ensure SB 1264's balance billing protections are properly implemented for the protection of consumers, the department has rejected this option.

(2) The department also considered exempting small or micro businesses from the requirements of the rule, but ultimately rejected this option for the same reasons outlined above. Additionally, exempting small or micro business from the proposed rules would result in enrollees receiving the notice and disclosure statement in some instances and not others, resulting in even greater confusion and potential harm for those SB 1264 is intended to protect.

(3) Finally, the department also considered imposing lesser requirements on small or micro businesses, but ultimately rejected this option for the same reasons outlined

above. Imposing lesser requirements on small or micro businesses would come at the expense of the enrollees SB 1264 was intended to protect. Furthermore, having different sets of requirements for providers based on their status as a small or micro business would cause confusion for the enrollees, the agencies enforcing these rules, and the providers themselves.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. Insurance Code §752.003 and §1467.003 provide that Government Code §2001.0045 does not apply to a rule proposed and adopted under those sections. Because these rules are proposed under Insurance Code §752.003 and §1467.003, these rules are not subject to Government Code §2001.0045. Nevertheless, even if §2001.0045 was applicable, the department is not required to repeal or amend another rule because the proposed rules are necessary to implement SB 1264 and to protect the health and financial welfare of the residents of this state, as previously explained.

GOVERNMENT GROWTH IMPACT STATEMENT. The department has determined that for each year of the first five years that the proposed rules are in effect the proposed rule:

- will not create a government program;
- will not require the creation of new employee positions;
- will not require an increase or decrease in future legislative appropriations to the agency;
- will not require an increase or decrease in fees paid to the agency;
- will create a new regulation;
- will not expand, limit, or repeal an existing regulation;
- will increase the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. The department will consider any written comments on the proposal that are received by the department no later than 5:00 p.m., central time, on February 10, 2020. Send your comments to ChiefClerk@tdi.texas.gov; or to the Office of the Chief Clerk, MC 112-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will also consider written and oral comments on the proposal in a public hearing under Docket No. 2819 at 1:00 p.m. central time, on February 4, 2020, in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The department requests that parties who plan to speak at the hearing send their written comments (or a summary of their testimony) to ChiefClerk@tdi.texas.gov by noon January 28, to facilitate a meaningful discussion.

STATUTORY AUTHORITY. The department proposes 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.

CROSS-REFERENCE TO STATUTE. The proposed new §§21.4901 - 21.4904 implement §§752.003, 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.

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 non-emergency 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 care 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 non-emergency 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. 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 non-emergency 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 must maintain a copy of the notice and disclosure statement, signed and dated by the enrollee, for four years. The provider must provide the enrollee with a copy of the signed notice and disclosure statement on the same date the statement is signed.

(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.

§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 proposal and found it to be within the agency's authority to adopt.

Issued in Austin, Texas, on December 20, 2019.

/s/ James Person
James Person, General Counsel
Texas Department of Insurance