

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

INTRODUCTION. The Commissioner of Insurance adopts new 28 TAC §§21.4901 - 21.4904, concerning disclosures by out-of-network providers, on an emergency basis, effective January 1, 2020. The emergency adoption is necessary to timely 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).

REASONED JUSTIFICATION. 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

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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.

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.

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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.

An emergency rule is necessary

Pursuant to Government Code §§2001.034 and 2001.036(a)(2), the new rules are adopted on an emergency basis and with an expedited effective date because an imminent peril to the public health, safety, or welfare requires adoption on fewer than 30 days' notice.

SB 1264 was enacted by the Legislature to help protect Texans from surprise balance bills, also known as surprise medical bills, when the consumer has no choice regarding their medical provider. When an insurance company fails to cover the cost of a medical service or supply provided by a physician or other provider that is not in the insurance company's network, the provider typically bills the patient for the remaining balance (including any applicable copayment, coinsurance, and deductible). This is commonly referred to as "balance billing." A balance bill is typically based on a provider's chargemaster rate, which can be highly inflated. See *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, 559 S.W.3d 128, 132 (Tex. 2018) ("Commentators lament the increasingly arbitrary nature of chargemaster prices, noting that, over time, they have lost any direct connection to costs[.]") (internal citation and quotations omitted). One study found that Texas, at 27%, has the third highest rate of out-of-network charges for services performed at in-network facilities. See The Peterson Center on Healthcare and Kaiser Family Foundation, *An Examination of Surprise Medical Bills and Proposals to Protect Consumers*

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From Them, October 2019, (www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/).

Medical debt was a significant factor in almost 60% of U.S. bankruptcies, according to a study published in the March 2019 American Journal of Public Health. The U.S. Consumer Financial Bureau reported that medical bills accounted for more than half of unpaid bills sent to collection agencies in 2014. 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. See Kaiser Family Foundation & Episcopal Health Foundation, *Texans' Experiences with Health Care Affordability and Access*, July 2018, (www.kff.org/health-costs/report/texans-experiences-health-care-affordability-access/) ("[R]oughly six in ten [Texas residents] say someone in their household has postponed or skipped some sort of medical care in the past year because of the cost."). The impact of balance billing to the public's health and financial welfare is clear.

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 unscrupulous providers from exploiting the law's narrow exceptions to the balance billing prohibition, which would exacerbate the balance billing emergency if allowed. 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

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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.

Because SB 1264 governs health care or medical services or supplies provided on or after January 1, 2020, the threat to consumers' health and financial welfare is imminent. For services or supplies provided before January 1, enrollees that receive a balance bill have the option to force their provider and health care plan to participate in mediation over the bill. But with the passage of SB 1264, enrollees will no longer have that option for services or supplies provided on or after January 1. Instead, SB 1264 will protect consumers from the effects of balance billing with new balance billing prohibitions and a claim dispute resolution process. It is imperative that the new balance billing prohibitions function as intended for the benefit of consumers, consistent with SB 1264, and the new rules are designed to do just that. Therefore, it is vital to the public health and welfare that the new rules go into effect no later than January 1, 2020.

Future rulemaking

Under Government Code §2001.034, this emergency rule may not be in effect for longer than 180 days. TDI intends to propose this or a similar rule under the normal rulemaking process and will consider any additional action necessary in the event unforeseen issues arise with the adopted sections. Future rulemaking may also provide additional guidance.

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STATUTORY AUTHORITY. The sections are adopted on an emergency basis with an expedited effective date of January 1, 2020, under Insurance Code §§36.001, 752.0003(c), and 1467.003; and Government Code §§2001.034 and 2001.036(a)(2).

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance 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.

Government Code §2001.034 provides that a state agency may adopt an emergency rule without prior notice or hearing if the agency finds that an imminent peril to the public health, safety, or welfare requires adoption of a rule on fewer than 30 days' notice.

Government Code §2001.036(a)(2) provides that if a state agency finds that an expedited effective date is necessary because of imminent peril to the public health, safety, or welfare, and subject to applicable constitutional or statutory provisions, a rule is effective immediately on filing with the secretary of state, or on a stated date less than 20 days after the filing date.

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 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 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. 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

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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.

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

Issued at Austin, Texas, on December 18, 2019.

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

The Commissioner adopts new §§21.4901 - 21.4904 on an emergency basis, effective January 1, 2020.

/s/ Kent C. Sullivan
Kent C. Sullivan
Commissioner of Insurance

Commissioner's Order No. **2019-6181**