

July 15, 2019

Via electronic submission to: [comments@tdi.texas.gov](mailto:comments@tdi.texas.gov)

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

## **PUBLIC COMMENT LETTER**

Re: Texas Department of Insurance Rules Implementing Senate Bill 1264

Dear Commissioner Sullivan:

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

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

### **Issue 1: Nonemergency Exemption**

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

SB 1264 allows a consumer to be balance billed for out-of-network nonemergency care if the provider gives the consumer "a complete written disclosure" that includes projected costs before providing the service. THA believes the nonemergency exemption should not apply when a patient is admitted to another level of care through the emergency department of a hospital and all or a portion of the care is denied by the payer. The facility will more than likely be unaware of the payer's determination that all or a portion of the patient's visit is deemed

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

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

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

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

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

## **Issue 2: Arbitration Process**

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

### **Issue 3: Payment Standards and Hold Harmless Provisions**

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

### **Issue 4: Benchmarking**

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

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

### **Issue 5: Other Considerations**

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

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

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

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

Mr. Kent Sullivan

July 15, 2019

Page 4 of 4

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



Respectfully submitted,

D. Cameron Duncan III  
Associate General Counsel  
Texas Hospital Association