Agenda Item: 7.9
Board Meeting on April 19-20, 2018
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Consideration of Proposed New 22 Tex. Admin. Code §217.23, relating to Balance Billing

Background: During the 85th Legislative Session, the Texas Legislature enacted Senate Bill (SB) 507, which amended the Insurance Code Chapter 1467, and became effective on September 1, 2107. Chapter 1467 originally applied only to facility-based physicians (ambulatory surgical center; birthing center; hospital, free standing emergency medical care facility). SB 507, however, expanded the provisions of the chapter to all health care providers, including nurses in certain circumstances.

SB 507 permits insured individuals (enrollees) to request mandatory mediation with a facility-based or emergency care provider if the individual receives a 'balance bill' exceeding $500 (after co-payments, deductibles, and co-insurance) from a facility for emergency services or services rendered by a facility-based provider. If requested, the provider and the insurer/administrator must attend and participate in the mediation. Prior to the mediation, all of the parties must participate in a mandatory informal settlement teleconference. If the matter is not resolved during the teleconference, a mediation will take place in the county where the health care services were rendered. The mediation will focus on whether the amount charged by the provider was excessive and whether the amount covered by the insurer/administrator was usual and customary or whether the amount paid was low. The mediator's fee is required to be spilt evenly among the provider and the insurer/administrator. Unsuccessful mediations will be referred to a special judge for a hearing in district court.

Except in the case of an emergency, and if requested by an enrollee, a health care provider must also provide to the enrollee an estimate of the costs an enrollee will be responsible for paying. This estimate must be provided before any health care services are rendered. If the provider obtains the individual's written acknowledgment of the estimated costs, the provider cannot be required to participate in mediation, so long as the billed amount is lower than or equal to the amount quoted in the estimate. Further, Chapter 1467 requires providers to include in their billing statements notice of the opportunity for mandatory mediation. Finally, once a provider has been informed of a mediation request, the provider may not seek collection activities against the insured individual while the claim is pending resolution.

Chapter 1467 also requires the imposition of an administrative penalty on providers who are found to have participated in mediation in bad faith.

The proposed amendments, attached as Attachment “A”, are necessary to implement the requirements of Chapter 1467 and to provide notice to licensees of their responsibilities under the chapter.

Board Action: Move to approve proposed new 22 Texas Administrative Code §217.23, relating to Balance Billing, *w*ith authority for the General Counsel to make editorial changes as necessary to clarify rule and Board intent and to comply with the formatting requirements of the *Texas Register*. If no negative comments and no request for a public hearing are received, move to adopt proposed new 22 Texas Administrative Code §217.23, relating to Balance Billing, as proposed.

Attachment “A”

§217.23. Balance Billing.

(a) Purpose. The purpose of this section is to implement the requirements of the Insurance Code Chapter 1467 and notify licensees of their responsibilities under that chapter.

(b) Applicability. This chapter applies to any facility-based or emergency care provider, as those terms are defined in the Insurance Code §1467.001, who bills an enrollee for out-of-network medical or health care services provided on or after January 1, 2018.

(c) Responsibilities of Licensee.

(1) Mediation.

(A) An enrollee, as that term is defined in the Insurance Code §1467.001(3), may request mediation of a settlement of an out-of-network health benefit claim if:

(i) the amount for which the enrollee is responsible to a facility-based or emergency care provider, after co-payments, deductibles, and co-insurance, including the amount unpaid by the administrator or insurer, is greater than $500; and

(ii) the health benefit claim is for emergency care or a health care or medical service or supply provided by a facility-based provider in a facility that is a preferred provider or that has a contract with the administrator.

(B) If an enrollee requests mediation under the Insurance Code Chapter 1467, the facility-based or emergency care provider must participate in good faith

in the mediation.

(C) Prior to participation in a mediation, all parties, including the facility-based or emergency care provider, must participate in an informal settlement teleconference not later than the 30th day after the date on which the enrollee submits the request for mediation. If the informal settlement teleconference is unsuccessful in resolving the matter, a mediation must be conducted in the county in which the health care or medical services were rendered.

(D) In a mediation under the Insurance Code Chapter 1467, the parties must evaluate:

(i) whether the amount charged by the facility-based or emergency care provider for the health care or medical service or supply is excessive;

(ii) whether the amount paid by the insurer or administrator represents the usual and customary rate for the health care or medical service or supply or is unreasonably low; and

(iii) the amount, after co-payments, deductibles, and co-insurance are applied, for which the enrollee is responsible to the facility-based or emergency care provider.

(E) The costs of a mediation under the Insurance Code Chapter 1467 shall be borne equally between the facility-based or emergency care provider and the insurer or administrator.

(F) In the event a mediation is unsuccessful, the matter must be referred to a special judge for resolution, as set forth in the Insurance Code §1467.057.

(G) A facility-based provider will not be required to participate in mediation to mediate a billed charge if, prior to providing a health care service or supply, the facility-based provider makes a disclosure, as set forth in paragraph (2) of this subsection, and obtains the enrollee's written acknowledgment of that disclosure, so long as the billed amount is less than or equal to the maximum amount projected in the disclosure.

(2) Billing Notices.

(A) Except in the case of an emergency, and if requested by an enrollee, a facility-based provider must provide a complete disclosure to the enrollee, prior to providing the health care or medical service or supply, that:

(i) explains that the facility-based provider does not have a contract with the enrollee's health benefit plan;

(ii) discloses projected amounts for which the enrollee may be responsible; and

(iii) discloses the circumstances under which the enrollee would be responsible for those amounts.

(B) A facility-based or emergency care provider must include a conspicuous, plain-language explanation of the mediation process available under the Insurance Code Chapter 1467, as set forth in §1467.0511, in a bill sent to each enrollee by the facility-based or emergency care provider.

(C) Collection Notices. On receipt of notice from the Texas Department of Insurance that an enrollee has made a request for mediation, the facility-based or

emergency care provider may not pursue any collection efforts against the enrollee for amounts other than co-payments, deductibles, and co-insurance, before the earlier of:

(i) the date the mediation is completed; or

(ii) the date the request to mediate is withdrawn.

(d) Complaint Investigation and Resolution.

(1) Bad faith.

(A) Except for good cause shown, on a report of a mediator and appropriate proof of bad faith mediation, the Board shall impose an administrative penalty.

(B) The following conduct constitutes bad faith mediation:

(i) failing to participate in the mediation, if participation in the mediation was required;

(ii) failing to provide information the mediator believes is necessary to facilitate an agreement; or

(iii) failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement.

(C) Failure to reach an agreement is not conclusive proof of bad faith mediation.

(2) Complaint process. A complaint may be filed with the Board by a mediator or by an enrollee who is not satisfied with a mediated agreement for improper billing practices. Complaints that do not involve delayed health care or medical care shall be assigned a Priority 4 status, as described in §213.13 of this title (relating to Complaint

Investigation and Disposition). After investigation, if the Board determines that a licensee has engaged in improper billing practices or has committed a violation of the Nursing Practice Act, Chapter 1467, or other applicable law, the Board will impose appropriate disciplinary action.