Agenda Item: 6.6
Board Meeting on July 19-20, 2018
Prepared by: Jena Abel

Consideration of Adoption of Proposed New 22 Tex. Admin. Code §217.23, relating to *Balance Billing*, including Written Comments Received and Results of Public Hearing, if any

Background: Proposed new §217.23 was approved by the Board at its April 2018 meeting for submission to the *Texas Register* for public comment. The proposal was published in the *Texas Register* on June 1, 2018, and the comment period ended on July 1, 2018. The Board received two written comments on the proposal. The Board did not receive any requests for a public hearing. A copy of the written comments received are attached hereto as Attachment "A".

The Board received one comment from a representative of the APRN Alliance. A second comment was received from a representative of the Texas Medical Association. A summary of the comments received and Staff's proposed responses to the written comments are attached as Attachment "B". Staff's recommended changes, with highlighted changes responsive to the written comments, are included in Attachment "C".

Board Action: Move to adopt new 22 Texas Administrative Code §217.23, relating to *Balance Billing*, with changes, as set out in Attachment "C". Further, authorize Staff to publish the summary of comments and response to comments attached hereto as Attachment "B".

April 13, 2018

James W. Johnston
Texas Board of Nursing
333 Guadalupe Street, Suite 3-460
Austin, Texas 78701

Re: *Proposed Rule §217.23, Balance Billing*

We appreciate the Board's adherence to the law in the development of this rule. As a coalition that represents all of the licensees affected by the rule, we recommend some minor, clarifying changes.

It would be helpful if the applicability subsection included the types of coverage that the rule applies to, similar to the language that the Texas Department of Insurance uses in 28 TAC 21.5002. The balance-billing law applies to coverage issued by an insurer as a preferred provider benefit plan or administered by an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579. *Tex. Ins. Code § 1467.002*. The provisions in this rule do not apply to all health benefit plan enrollees, and providing a clear and accurate applicability section will help licensees understand their responsibilities under this rule.

Additionally, we ask that the Board include a provision notifying licensees that, by law, they are not subject to discipline for failing to disclose the amount for which the enrollee may be responsible prior to providing the service, nor for failing to include a conspicuous explanation of the mediation process in a bill. *Tex. Ins. Code § 1467.151*. While we agree that licensees should provide this information, they should not fear discipline if they fail to do so.

The Board should also take this opportunity to clarify that licensees may send a representative to an informal settlement conference and mediation. When the Board uses language saying that the provider "must participate," it raises a question as to whether the Board is requiring more than the law requires. The law is clear that a "party" means a provider "or the provider's representative." *Tex. Ins. Code § 1467.001(7)*. Including this clarification will ensure that providers do not unnecessarily take time off from treating patients.

Finally, rather than stating that the board will impose disciplinary action when it determines the licensee has engaged in "improper billing practices *or* has committed a violation of the Nursing Practice Act," we recommend modifying that language to read "improper billing practices *that violate* the Nursing Practice Act." The proposed language implies that the Board's investigation of an improper billing complaint will extend to unrelated practice violations.

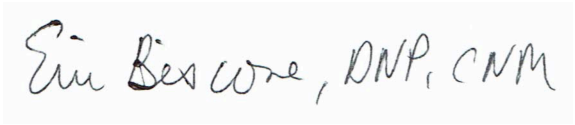
We thank you for this opportunity to provide our perspective on the proposed Balance Billing rule. Please do not hesitate to contact us with questions or for further input.

Sincerely,

Jeff Watson, DNP, RN-BC, NEA-BC, NE-BC, CRRN
President, Texas Nurses Association

Tim Jones, DNP, CRNA
President, Texas Association of Nurse Anesthetists

Robert Metzger, DNP, APRN, FNP-BC
President, Texas Nurse Practitioners



Erin Biscone, DNP, CNM
President, Consortium of Certified Nurse-Midwives

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

June 29, 2018

James W. Johnston
General Counsel
Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, TX 78701

Via email to dusty.johnston@bon.texas.gov

Re: Comments on Proposed Rule 22 Tex. Admin. Code § 217.23 (43 Tex. Reg. 3567 et seq.)

Dear Mr. Johnston:

The Texas Medical Association (TMA) is a private, voluntary, nonprofit association of more than 51,000 Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the health of all Texans." TMA's diverse physician members practice in all fields of medical specialization.

TMA appreciates the opportunity to provide comment on the Texas Board of Nursing's (BON) proposed rules in 22 TAC Chapter 217, as published in the Texas Register on June 1, 2018 (43 TexReg 3567 et. seq.).

I. Proposed §217.23. Balance Billing

A. Proposed §217.23. Balance Billing – Heading

In its rule proposal, the BON begins by proposing a new §217.23 with the heading "Balance Billing." TMA notes that the provisions in the rule proposal are intended to implement the requirements of Chapter 1467 of the Texas Insurance Code. That chapter of the Insurance Code specifically addresses out-of-network health benefit claim dispute resolution, rather than balance billing generally. Acknowledging this fact, the Texas Legislature purposefully entitled Chapter 1467 "out-of-network claim dispute resolution."

In order to properly describe the subject matter of the proposed new BON rule section and to avoid confusion by members of the regulated community as well as lay persons regarding the scope of rule, TMA recommends that the BON modify the proposed §217.23 heading to read as follows: "§217.23 Out-of-Network Health Benefit Claim Dispute Resolution."

Making this modification would more closely align the rule proposal with its statutory basis and would also be more consistent with the manner in which the Texas Medical Board (TMB) has historically identified its rules implementing Chapter 1467 of the Texas Insurance Code (see 22 TAC 187.85 et seq).

B. Proposed §217.23(a). Purpose

Next, in proposed §217.23(a), the BON states the purpose of its new rule proposal as follows:

> (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. (emphasis added).

While the purpose of the section is correctly stated, TMA notes that the term "licensee" is not defined in Chapter 217 or in §217.23 of the BON rules. TMA assumes that the BON intends for "licensee" to be limited to the BON's own licensees, as these are the only licensees over whom the BON has regulatory authority (and the BON's other references in Chapter 217 appear to be directed at its own licensees). However, in the interest of clarity, TMA recommends including a specific definition in proposed §217.23 limiting "licensee" to the BON's "licensees," similar to the definition used in 22 TAC §213.1(23), which is as follows:

> a person who has met all the requirements to practice as a registered or vocational nurse pursuant to the Nursing Practice Act and the Rules and Regulations relating to Nurse Education, Licensure and Practice and has been issued a license to practice professional or vocational nursing in Texas. For purposes of this subchapter, the term includes a person who practices pursuant to a multistate licensure privilege.

C. Proposed §217.23(b). Applicability

Next, TMA **strongly objects** to proposed §217.23(b)'s language regarding the rule's applicability due to its overly broad drafting. Specifically, subsection (b) makes a significant error when it states that the proposed rule would apply to "***any*** facility-based provider or emergency care provider, as those terms are defined in the Insurance Code §1467.001, who bill an enrollee for out-of-network emergency care, health care, or medical service or supply provided on January 1, 2018." (emphasis added).

According to §1467.001 of the Insurance Code, the terms "facility-based provider" and "emergency care provider" may include certain nurses, but the terms also expressly include certain physicians (as well as a host of others), as that section of the law provides the following:

> "Emergency care provider" means **a physician**, health care practitioner, facility, or other health care provider who provides and bills an enrollee, administrator, or health benefit plan for emergency care. (emphasis added).

> "Facility-based provider" means **a physician**, health care practitioner, or other health care provider who provides health care or medical services to patients of a facility. (emphasis added) .

The BON's proposed rules, as currently drafted, therefore purport to apply not only to BON licensees, but also to physicians and numerous other individuals and facilities who are clearly outside the regulatory authority of the BON. **TMA strongly objects to the BON adopting any rule that imposes any requirement on or otherwise regulates any physician.**

The fact that these proposed rules exceed the BON's statutory authorization is clearly established. In the preamble to the rule proposal, the BON cites Occupations Code §301.151 and Insurance Code §1467.003 as the statutory authority for the rule proposal.[1]

Notably, Occupations Code §301.151 provides that the BON may adopt rules only to "regulate the practice of professional nursing and vocational nursing" and to establish "standards of professional conduct for license holders under [Chapter 301]." There is no mention of any authority to adopt or enforce rules relating to any health care profession other than nursing.

Additionally, Insurance Code §1467.003 states that "the [Texas Department of Insurance] commissioner, the Texas Medical Board, any other appropriate regulatory authority, and the chief administrative law judge shall adopt rules as necessary to implement their respective powers and duties under this chapter." This language clearly contemplates the BON adopting rules relating exclusively to its own licensees (i.e., to implement its respective powers and duties) and other agencies regulating their own licensees.

The authority to regulate the practice of medicine and physicians is expressly reserved to the TMB by the Medical Practice Act (§151.003, Texas Occupations Code), as well as by Insurance Code §1467.003 (in the specific context of Chapter 1467 matters).[2] In the past, the TMB has exercised its authority to implement its powers and duties under Chapter 1467 of the Insurance Code by promulgating its rules at 22 TAC §187.85 et seq. TMA fully expects the TMB to amend its existing rules in light of SB 507's passage (as this has previously been a topic of discussion in stakeholder meetings with TMB staff).

Were the BON to adopt rules relating to out-of-network health benefit claim dispute resolution that apply to physicians, it would not only violate statute and exceed its statutory authority, but it would also create confusion, establishing two different and possibly conflicting sets of rules that purport to regulate physicians' involvement in out-of-network health benefit claims dispute resolution.

To resolve this issue, TMA recommends that the BON modify proposed subsection (b) to read as follows:

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[1] 43 TexReg 3570 (June 1, 2018).

[2] The Texas Legislature states that the TMB is the agency authorized for "licensing, regulating, and disciplining physicians," (§151.003, Texas Occupations Code) and only the TMB is thus authorized to adopt rules necessary to "regulate the practice of medicine" (§153.001(3), Texas Occupations Code).

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

Making this change would ensure consistency with the rules' stated purpose in proposed §217.23(a), which is to "notify [BON] licensees of their responsibility under [Chapter 1467, Insurance Code]."

II. Definitions

Next, TMA notes that the BON's rule proposal uses many terms that have specialized meaning and definitions under Chapter 1467 of the Insurance Code, yet the BON does not include a definitions subsection in the rule proposal or otherwise note that it is deferring to the statutory definitions for those terms. For example, the following terms that are used in the rule proposal have specific definitions under Chapter 1467 of the Insurance Code: "emergency care," "mediation," "facility," "administrator," and "party."

To ensure alignment of the rule with the statutory terminology, TMA recommends that the BON include a new subsection stating as follows:

> (_) Definitions. Terms defined in Insurance Code §1467.001 have the same meanings when used in this section unless the context clearly indicates otherwise.

III. Proposed §217.23(c) Responsibilities of Licensees.

Next, in proposed §217.23(c), the BON sets forth the responsibilities of its licensees with regard to mediation, billing notices, and collection notices.

A. Proposed §217.23(c)(1). Mediation – General Comments

TMA notes that the BON's rule proposal in proposed §217.23(c)(1) is duplicative of much of the language in Chapter 1467 of the Insurance Code and TMA contends that this language does not need to be recited in the rules in order to clearly set forth a BON licensee's obligations under Chapter 1467 of the Insurance Code. For example, the TMB has historically not repeated the basic requirements for mediation in its rules and instead has focused on the physician's responsibilities with regard to disclosures/billing notices and complaints (e.g., bad faith mediation and improper billing**). TMA recommends that, for clarity and consistency across regulatory agencies, the BON take a similar approach with regard to its licensees and that the BON strike the proposed language in §217.23(c)(1) in its entirety.**

Alternatively, should the BON retain proposed §217.23(c)(1) (over TMA's objections), then we recommend that the BON more closely track the underlying statutory language in paragraph(c)(1), as noted in the comments below.

B. **Proposed §217.23(c)(1)(A)**

First, TMA recommends that if the BON retains §217.23(c)(1), the BON separate the provisions in (c)(1)(A)(ii) to read as follows (as stated in the Insurance Code):

> (ii) the health benefit claim is for:
> (I) emergency care; or
> (II) 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.

TMA contends that separating the (ii) clause into two subclauses will aid the regulated community in understanding which claims are eligible for mediation and will ensure that the rule language more closely tracks the statute.

C. **Proposed §217.23(c)(1)(B) – Requirement to Participate in Mediation**

Next, in proposed §217.23(c)(1)(B), the proposed rule states the following:

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

TMA notes that this proposed rule language departs from the underlying statutory language in two important respects. First, the rule proposal omits language present in the statute that grants providers the flexibility to have their representative participate in mediation. The statutory language (found in §1467.051(b) of the Insurance Code) clearly requires "… the facility based provider or emergency care provider, ***or the provider's representative***, and the insurer or the administrator, as appropriate, to participate in the mediation." (emphasis added).

Given the significant time investment required to participate in mediation, this omission could detrimentally impact licensees who are subject to the rule. Without permitting the representative to participate in lieu of the provider, the provider would be forced to lose valuable time that could otherwise be dedicated to patient care. Thus, TMA recommends that the BON amend its rule proposal to track the statutory language with regard to a representative's participation in mediation.

Secondly, TMA notes that proposed §217.23(c)(1)(B) departs from the underlying statutory language by imposing a "good faith" standard on mediation participation that is not present in §1467.051(b) of the Insurance Code. Presumably, the BON inserted a "good faith" standard into §217.23(c)(1)(B) of the rule proposal based upon the statutory language that relates to reports of "bad faith" mediation (i.e., §§1467.101 and 1467.102 of the Insurance Code).

However, TMA contends that the addition of the "good faith" language is unnecessary and will lead to confusion in the enforcement of the rule. More specifically, the "good faith" language in proposed §217.23(c)(1)(B) is unnecessary, because subsection (d)(1) of the rule proposal specifically addresses bad faith mediation by tracking the statute's language. Additionally, the "good faith" language adds nothing of value to the rule proposal (and actually detracts from the rule proposal), because it makes what once was clear (i.e., that bad faith mediation is statutorily limited to three types of conduct) now open to interpretation. In other words, it could lead one to question: does the "good faith" participation requirement create a different or a higher standard than the statutory requirement ***not*** to participate in "bad faith," which is limited to three itemized elements under the statute or does it impose the same standard? TMA recommends that the BON resolve this uncertainty by either deleting (c)(1) in its entirety as suggested above or by striking "good faith" from proposed §217.23(c)(1)(B) .

In order to address the foregoing concerns, TMA recommends that, if (c)(1)(B) is retained (over TMA's objections), it be modified to read as follows:

> (B) Except as provided by subparagraph (G), if an enrollee requests mediation under the Insurance Code Chapter 1467, the facility-based or emergency care provider, or the provider's representative, shall participate in [~~good faith in~~] the mediation.

D. **Proposed §217.23(c)(1)(D)**

Next, if the BON retains proposed (c)(1), TMA recommends that the BON more closely track the underlying statutory language and amend proposed §217.23(c)(1)(D) as follows:

> (D) In a mediation under the Insurance Code Chapter 1467, the parties must:
> (i) evaluate whether:
> (I) the amount charged by the facility-based or emergency care provider for the health care or medical service or supply is excessive; and
> (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
> (ii) as a result of the amounts described by clause (i), determine the amount, after copayments, deductibles, and coinsurance are applied, for which an enrollee is responsible to the facility-based or emergency care provider.

Additionally, if the BON includes the language in proposed §217.23(c)(1)(D), then it would also be important to include the following related statutory language in the rule proposal:

> (_) The goal of the mediation under the Insurance Code Chapter 1467 is to reach an agreement among the enrollee, the facility-based provider or emergency care provider, and the insurer or administrator, as applicable, as to the amount paid by the insurer or administrator to the facility-based provider or emergency care provider, the amount charged by the facility-based provider or emergency care

provider, and the amount paid to the facility-based provider or emergency care provider by the enrollee.

E. **Proposed §217.23(c)(1)(E)**

Next, TMA notes that Insurance Code §1467.053 requires the ***mediator's fees*** (and not any other costs associated with mediation) to be split evenly and paid by the insurer or administrator and the facility-based provider or emergency care provider. Accordingly, if the BON retains (c)(1), TMA recommends that the BON modify its proposed §217.23(c)(1)(E) to more closely track the statutory language, as follows:

(E) The mediator's fees for [~~costs of~~] a mediation under Chapter 1467 shall be split evenly and paid by [~~borne equally between~~] the facility-based or emergency care provider and the insurer or administrator.

F. **Proposed §217.23(c)(1)(F)**

Next, if the BON retains proposed (c)(1) (over TMA's objections), then TMA recommends that the BON modify proposed §217.23(c)(1)(F) to more closely track the statutory language as follows:

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

G. **Proposed §217.23(c)(1)(G)**

Next, TMA recommends that if proposed §217.23(c)(1) is retained the BON modify proposed §217.23(c)(1)(G) to more closely track the underlying statutory language so that it reads as follows:

(G) A facility-based provider will not be required to [~~participate in mediation to~~] mediate a billed charge under Insurance Code Chapter 1467 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.

H. Proposed §217.23(c)(2). Billing Notices

1. **Proposed §217.23(c)(2)(A). Disclosure of Out-of-Network Status and Projected Amounts**

Next, the BON includes language in its rule proposal regarding billing notices and disclosures that must be provided under Chapter 1467 of the Insurance Code.

In proposed §217.23(c)(2)(A), the BON tracks the statutory language that sets forth a facility-based provider's disclosure requirements regarding out-of-network status and projected amounts for which the enrollee may be responsible. However, TMA contends that logically only ***out-of-network*** facility-based providers should be required to meet the disclosure obligations under §217.23(c)(2)(A), since the first element of the disclosure obligation is a requirement to explain that the provider does not have a contract with the enrollee's health benefit plan.

Thus, TMA recommends that the BON amend the language to read as follows:

> (A) Except in the case of an emergency, and if requested by an enrollee, an <u>out-of-network</u> 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.

2. **Proposed §217.23(c)(2)(B). Disclosure of the Mediation Process.**

Next, in proposed §217.23(c)(2)(B), the BON attempts to recite the facility-based provider and emergency care provider's statutory responsibilities regarding plain language explanations of mediation on certain bills. TMA contends that the proposed language, however, is overly broad in that it would require a facility-based or emergency care provider to include the explanation on ***any*** bill sent to an enrollee. In other words, the rule's requirement would not be limited to out-of-network bills subject to mediation under Chapter 1467 and would, for example, even apply to in-network bills. This rule, if strictly adhered to, would result in confusion among enrollees regarding the circumstances when mediation is available. Consequently, such a broad disclosure requirement would be counterproductive.

Therefore, TMA recommends that BON modify its proposed rule to narrow the scope of the requirement as follows:

> (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 provider or emergency care provider <u>for an out-of-network health benefit claim eligible for mediation under Insurance Code Chapter 1467</u>.

3. **Proposed Addition of §217.23(c)(2)(C). Disclosures not Subject to Discipline.**

Next, TMA notes, that proposed BON rules are silent as to the consequences of a licensee's failure to comply with disclosures required under proposed §217.23(c)(2)(A) and (B). This

silence stands in stark contrast to §1467.151(d) of the Insurance Code, which clearly indicates that any failure to provide the disclosures required under §§1467.051 and 1467.0511 of the Insurance Code (i.e, the statutory analogs to proposed §217.23(c)(2)(A) and (B)) is not subject to discipline by the appropriate regulatory agency.

To fill this gap in the rules and ensure proper notice to licensees, TMA contends that the BON's proposed rules should be modified to add a new §217.23(c)(2)(C), stating the following:

> (C) A facility-based provider or emergency care provider who fails to provide a disclosure under §217.23(c)(2)(A) or (B) is not subject to discipline for that failure.

D. Proposed §217.23(c)(3). Collection Notices

Next, TMA recommends that the BON modify proposed §217.23(c)(3) to more closely track §1467.055 of the Insurance Code and to clarify that the mediation request must meet the requirements of Chapter 1467 of the Insurance Code in order to trigger the responsibility not to pursue collection efforts.

To that end, TMA recommends that proposed §217.23(c)(3) be modified as follows:

> (3) Collection Notices. On receipt of notice from the Texas Department of Insurance that an enrollee has made a request for mediation that meets the requirements of Insurance Code Chapter 1467, the facility-based or emergency care provider may not pursue any collection efforts against the enrollee for amounts other than co-payments, deductibles, and coinsurance, before the earlier of the date the mediation is completed or the date the request to mediate is withdrawn.

IV. Proposed §217.23(d)(2) – Complaint Investigation and Resolution

Next, TMA recommends that the BON modify the language in proposed §217.23(d)(2) to: (1) more clearly denote that the complaint made by a mediator referenced in §217.23(d)(2) concerns bad faith mediation and (2) align the improper billing language with language from §311.0025 of the Health and Safety Code.

With TMA's recommended amendments, proposed §217.23(d)(2) would read as follows:

> (2) Complaint process. A complaint may be filed with the Board by a mediator against a licensee for bad faith mediation 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. In accordance with §311.0025 of the Health and Safety Code, the Board shall not open investigations relating to complaints of a single instance of improper billing, but shall open investigations on facility-based or emergency care providers who are alleged to have engaged in improper billing in multiple instances.

Additionally, TMA notes that this language would better align with the TMB's historic interpretation of the same statutory provisions, as currently found in TMB rules at 22 TAC 187.88.

V. Conclusion

TMA again expresses appreciation for the opportunity to provide comment on these proposed rules. Should you have any questions, please contact any of the following TMA staff at TMA's toll free number (800-880-1300): Kelly Walla, Associate Vice President and Deputy General; Genevieve Davis, Associate Vice President, Payment Advocacy; Jared Livingston, Assistant General Counsel; or Clayton Stewart, Director, Legislative Affairs.

Sincerely,

Douglas W. Curran, MD
President
Texas Medical Association

DWC: KMW

Attachment “B”

Summary of Comments Received

General Comments

Summary of Comment: A commenter representing the APRN Alliance suggests adding a provision notifying licensees that, by law, they are not subject to discipline for failing to disclose the amount for which the enrollee may be responsible prior to providing the service, nor for failing to include a conspicuous explanation of the mediation process in a bill. The commenter states that, while the APRN Alliance agrees that licensees should provide this information, they should not fear discipline if they fail to do so.

A commenter representing the Texas Medical Association states that the Board’s rules are silent as to the consequences of a licensee’s failure to comply with required disclosures, which stands in stark contrast to the Insurance Code §1467.151(d), which clearly indicates that any failure to provide the required disclosures is not subject to discipline by the appropriate regulatory agency. The commenter suggests adding a statement to the rule that specifies that a licensee is not subject to discipline for failure to provide the required disclosures.

Agency Response: The Board declines to make these suggested changes. A licensee is required under the Insurance Code §1467.051(c), if requested by an enrollee, to provide a complete disclosure to the enrollee before providing a health care or medical service or supply, as specified in that statutory subsection. Further, §1467.0511(a) requires all bills for out-of-network health benefit claims eligible for mediation sent to enrollees by a facility-based provider or emergency care provider to contain a conspicuous explanation of the mediation process, as specified in that statutory subsection. Nonetheless, the Board recognizes §1467.151(d), which precludes disciplinary action based upon a licensee’s failure to provide a disclosure under §1467.051 or §1467.0511. No provision of the rule runs contrary to that statutory provision or implies otherwise. The Board, however, does not find it necessary to repeat the statutory prohibition in the rule.

Summary of Comment: A commenter representing the APRN Alliance suggests clarifying that licensees may send a representative to an informal settlement conference and mediation. The commenter cites to the statutory definition of ‘party’ in §1467.001(7) to support this suggestion. The commenter states that the rule text as proposed may raise questions as to whether the rule requires more than the law requires.

A commenter representing the Texas Medical Association points out that the statute permits a provider’s representative to participate in mediation. The commenter recommends that the rule be amended for consistency with this provision

Agency Response: The Board agrees that Chapter 1467 allows a representative to attend an informal settlement conference or mediation on the licensee’s behalf and has added clarifying language to subsection (c) of the rule text as adopted.

Summary of Comment: A commenter representing the Texas Medical Association recommends changing the title of the new section to read “Out-of-Network Health Benefit Claim Dispute Resolution”. The commenter states that the suggested title better describes the subject matter of the rule section and will help avoid confusion by members of the regulated community and lay persons. The commenter also states that this change would be more consistent with the manner in which the Texas Medical Board has historically identified its rules implementing the Insurance Code Chapter 1467.

Agency Response: The Board agrees that the subject matter of the section relates to out-of-network claim dispute resolution, also known as ‘balance billing’, and has, therefore, changed the title as adopted to “Balance Billing Dispute Resolution”. The Board does not agree that the phrase “balance billing” is confusing or misrepresents the context of the section or the intent of the Insurance Code Chapter 1467. To the contrary, the Board believes this phrase will be easier for enrollees, licensees, and the general public to understand. As such, the Board declines to make further changes to the section’s title.

Summary of Comment: A commenter representing the Texas Medical Association recommends including definitions in the rule for the terms that are defined in the Insurance Code Chapter 1467 and also appear in the rule.

Agency Response: The Board agrees and has added the commenter’s suggested language to the rule as adopted.

§217.23(a). Purpose.

Summary of Comment: A commenter representing the Texas Medical Association notes that the term ‘licensee’ is not defined in the new section or Chapter 217 of the Board’s rules. The commenter suggests, in the interest of clarity, that the Board include a specific definition of the term ‘licensee’ in the rule.

Agency Response: The Board declines to make this change. The Board does not believe the term is confusing within the context of the section, and the Board acknowledges it only has jurisdiction over its own licensees.

§217.23(b). Applicability.

Summary of Comment: A commenter representing the APRN Alliance states that it would be helpful if the Board included the types of coverage that the rule applies to in the applicability section. The commenter states that the balance billing law applies to coverage issued by an insurer as a preferred provider benefit plan or administered by an administrator of a health benefit plan, other than a health maintenance organization plan. The commenter further states that the provisions of the rule do not apply to all health benefit plan enrollees, and providing a clear and accurate applicability section will help licensees understand their responsibilities under the rule.

Agency Response: The Board agrees and has added clarifying language to subsection (b) of the rule text as adopted.

Summary of Comment: A commenter representing the Texas Medical Association states that the use of the phrase *any* "facility-based provider" and "emergency care provider" in the subsection could be interpreted to include physicians, as well as nurses. The commenter re-iterates that the Board does not have jurisdiction over physicians and objects to any rule that imposes any requirement on or otherwise regulates any physician. The commenter suggests clarifying that the rule only applies to a Board licensee that is also a "facility-based provider" or "emergency care provider", as those terms are defined in the Insurance Code §1467.001.

Agency Response: The Board agrees in part and disagrees in part. Because the Board only has jurisdiction over its own licensees, an interpretation of this subsection that seeks to expand that jurisdiction is unlikely and without merit. Nevertheless, the Board has added language to the subsection as adopted to clarify that the section only applies to individuals over which the Board has jurisdiction.

§217.23(c)(1). Mediation.

Summary of Comment: A commenter representing the Texas Medical Association states that subsection (c)(1) of the rule text is unnecessarily duplicative of the statutory language in the Insurance Code Chapter 1467. Further, the commenter states that the Texas Medical Board has not historically repeated the basic requirements for mediation in its rules, and instead, has focused on the physician's responsibilities with regard to disclosures/billing notices and complaints (e.g., bad faith mediation and improper billing). The commenter recommends that the language in (c)(1) be stricken in its entirety.

Agency Response: The Board declines to make this change. The Board believes it is important to re-iterate in its own rules a licensee's primary obligations under the Insurance Code Chapter 1467 in an easily comprehensible manner.

§217.23(c)(1)(A).

Summary of Comment: A commenter representing the Texas Medical Association recommends that, if the Board retains subsection (c)(1), that the Board separate the provisions of (c)(1)(A)(ii). The commenter contends that separating the clause into two subclauses will aid the regulated community in understanding which claims are eligible for mediation and will ensure that the rule language more closely tracks the statute.

Agency Response: The Board agrees and has amended the text as adopted in subsection(c)(1)(A)(ii) accordingly.

§217.23(c)(1)(B).

Summary of Comment: A commenter representing the Texas Medical Association states

that the Board imposes a 'good faith' standard on mediation participants that is not found in the statute. The commenter further states that this addition is unnecessary because subsection (d)(1) of the rule proposal specifically addresses bad faith mediation by tracking the statute's language. The commenter recommends deleting (c)(1) in its entirety or striking the term "good faith" from (c)(1)(B).

Agency Response: The Board agrees and has removed the phrase "good faith" from the rule text as adopted.

§217.23(c)(1)(D).

Summary of Comment: A commenter representing the Texas Medical Association recommends stylistic changes to the subparagraph. The commenter recommends adding "as a result of the amounts described by clause (i), determine the" at the beginning of clause (ii) of the subparagraph. The commenter also suggests adding statutory language regarding the goal of mediation found in the Insurance Code §1467.056(d).

Agency Response: The Board agrees in part and disagrees in part. The Board agrees that the rule text could more closely track the statutory language in §1467.056(a) and has made changes to the rule text as adopted accordingly. The Board declines to include the additional language suggested by the commenter. This language is not necessary and does not address any additional licensee responsibility or obligation.

§217.23(c)(1)(E).

Summary of Comment: A commenter representing the Texas Medical Association suggests that the rule text be changed to reflect that the mediator's fees (and not any other costs associated with mediation) are to be split evenly and paid by the insurer or administrator and the facility-based provider or emergency care provider.

Agency Response: The Board agrees and has changed the text of the rule as adopted accordingly.

§217.23(c)(1)(F).

Summary of Comment: A commenter representing the Texas Medical Association suggests that the phrase "for resolution" be struck from the rule text to more closely track the statutory language.

Agency Response: The Board agrees and has changed the text of the rule as adopted accordingly.

§217.23(c)(1)(G).

Summary of Comment: A commenter representing the Texas Medical Association suggests that the phrase "participate in mediation to" be stricken from the subparagraph

and the phrase “under the Insurance Code Chapter 1467" be added to the subparagraph.

Agency Response: The Board declines to make this change. The purpose of the section is to implement the requirements of the Insurance Code Chapter 1467 and notify licensees of their responsibilities under that chapter. It is clear that the requirements of the section regarding a mediation apply in that context.

§217.23(c)(2)(A)

Summary of Comment: A commenter representing the Texas Medical Association suggests adding the phrase “out-of-network” before “facility-based provider”. The commenter states that only out-of-network facility-based providers should be required to meet the disclosure obligation, since the first element of the disclosure obligation is a requirement to explain that the provider does not have a contract with the enrollee’s health benefit plan.

Agency Response: The Board agrees and has amended the rule text as adopted accordingly.

§217.23(c)(2)(B)

Summary of Comment: A commenter representing the Texas Medical Association states that the rule contains overly broad language in that it would require a facility-based or emergency-care provider to include the explanation on *any* bill sent to an enrollee, and would not be limited to out-of-network bills subject to mediation under the Insurance Code Chapter 1467, and would even apply to in-network bills. The commenter recommends that the Board narrow the scope of the requirement by including reference to an “out-of-network health benefit claim eligible for mediation under Insurance Code Chapter 1467" in the rule text.

Agency Response: The Board agrees that additional clarification is needed in this subparagraph and has amended the rule text as adopted accordingly.

§217.23(c)(3)

Summary of Comment: A commenter representing the Texas Medical Association suggests that the rule be modified to clarify that the mediation request must meet the requirements of the Insurance Code Chapter 1467 in order to trigger the responsibility not to pursue collection efforts.

Agency Response: The Board agrees that the suggested change tracks the statutory language and has made the changes to the rule text as adopted accordingly.

§217.23(d)(2).

Summary of Comment: A commenter representing the APRN Alliance suggests

modifying the language of the rule to read “improper billing practices *that violate* the Nursing Practice Act” instead of “improper billing practices *or* has committed a violation of the Nursing Practice Act”. The commenter states that the proposed language implies that the Board’s investigation of an improper billing complaint will extend to unrelated practice violations.

Agency Response: The Board declines to make the change. If a licensee’s conduct constitutes a violation of the Nursing Practice Act, Chapter 1467, or other applicable law, such as the Health and Safety Code §311.0025, the Board is authorized to review that conduct and take appropriate disciplinary action. A licensee’s conduct may only implicate a singular statute or rule, but it may also implicate more than one. In such event, the Board retains authority to review the conduct pursuant to all applicable standards.

Summary of Comment: A commenter representing the Texas Medical Association suggests that the paragraph include language that denotes that a complaint made by a mediator must concern bad faith mediation. Further, the commenter suggests adding language regarding improper billing practices under the Health and Safety Code §311.0025, in that the Board shall not open investigations relating to complaints of a single instance of improper billing, but shall open investigations on facility-based or emergency care providers who are alleged to have engaged in improper billing in multiple instances. The commenter adds that this addition would better align with The Texas Medical Board’s historic interpretation of the same statutory provisions.

Agency Response: The Board agrees in part and disagrees in part. The Board agrees with the suggestion of the commenter to include language that denotes “bad faith mediation” and has made the change to the adopted rule text accordingly. However, the Board declines to include the additional suggested language regarding improper billing practice under the Health and Safety Code §311.0025. The Board retains authority to investigate a licensee’s conduct and take disciplinary action where such conduct violates statutory standards or Board rules. This includes instances of improper billing practices. However, the Board is bound by statutory prohibitions such as those found in §311.025 and would not initiate disciplinary action based upon such conduct. The Board does not find it necessary to re-iterate those statutory prohibitions in the rule as adopted.

Attachment “C” (proposed changes as a result of comments received)

§217.23. Balance Billing Dispute Resolution.

(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) Definitions and Applicability of Section.

(1) Definitions. Terms defined in the Insurance Code §1467.001 have the same meanings when used in this section, unless the context clearly indicates otherwise.

(2) Applicability. This section applies to any facility-based provider or emergency care provider, as those terms are defined in the Insurance Code §1467.001, who bills an enrollee covered by a preferred provider benefit plan offered by an insurer under the Insurance Code Chapter 1301 or a health benefit plan, other than a health maintenance organization plan, under the Insurance Code Chapters 1551, 1575, or 1579, for out-of-network emergency care, health care, or medical service or supply provided on or after January 1, 2018. This section is limited to facility-based providers and emergency care providers that are subject to the Board’s jurisdiction.

(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:

(I) emergency care; or

(II) 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 or their representative must participate in the mediation.

(C) Prior to participation in a mediation, all parties, including the facility-based or emergency care provider, or their representative, 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:

(i) evaluate whether:

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

(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

(ii) as a result of the amounts described by clause (i) of this subparagraph, determine 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 mediator's fees for a mediation under the Insurance Code Chapter 1467 shall be split evenly and paid by 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, 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, an out-of-network 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) Each bill sent to an enrollee by a facility-based or emergency care provider for an out-of-network health benefit claim (balance bill) eligible for mediation under the Insurance Code Chapter 1467 must include a conspicuous, plain-language explanation of the mediation process available under Chapter 1467, as well as the information specified in §1467.0511.

(3) Collection Notices. On receipt of notice from the Texas Department of Insurance that an enrollee has made a request for mediation that meets the requirements of the Insurance Code Chapter 1467, 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 the date the mediation is completed or 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 against a licensee for bad faith mediation or by an enrollee who is not satisfied with a mediated agreement. 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.