Agenda Item: 6.2
Board Meeting on January 21-22, 2021
Prepared by: Jena Abel

Consideration of Adoption of Proposed Amendments to 22 Tex. Admin. Code §217.23, relating to *Balance Billing Dispute Resolution*

Background: Proposed amendments to §217.23 were approved by the Board at its October 2020 meeting for submission to the *Texas Register* for public comment. The proposal was published in the *Texas Register* on November 27, 2020, and the comment period ended on December 28, 2020. The Board received two 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".

A summary of the comments received and Staff's proposed responses are attached as Attachment "B". Staff recommends that a change be made to the rule text as adopted in response to one of the comments.

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

December 23, 2020

Mr. James W. Johnson
General Counsel
Texas Board of Nursing
333 Guadalupe, Suite S-460
Austin, TX 78701

Dear Mr. Johnson,

On behalf of Quest Diagnostics, we appreciate the opportunity to offer comments on the proposed amendments to §217.23, relating to Balance Billing Dispute Resolution. Quest Diagnostics is the world's leading provider of diagnostic information services and serves one in three adult Americans and half the physicians and hospitals in the United States annually. We are particularly proud of our presence in Texas, which is the home to our Southwest Region headquarters, and includes over 3,600 employees, 2 labs, and 174 patient service centers. With our robust infrastructure in Texas, we service over 38,000 physicians and 222 hospitals, and handle 48,000 patient specimens daily.

Quest's commitment to Texas has only strengthened in response to the COVID-19 pandemic. To date, we have already conducted nearly 1.6 million viral COVID-19 tests and over 182,000 serology tests to detect COVID-19 antibodies.

We applaud the State's focus on the important issue of surprise and balance billing. However, we propose minor amendments to these regulations to make them even stronger and effective. Specifically, we recommend setting a minimum required payment to out-of-network providers of 150% of the Medicare rate. While it is important to protect patients from receiving surprise bills, it is also important to ensure that providers, particularly clinical labs, receive fair and reasonable reimbursement for the services they perform.

Thank you for the opportunity to comment on these regulations, and please feel free to reach out if we can answer any questions.

Sincerely,

David M. Reiner
David M. Reiner
Sr. Director, State Government Affairs

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

December 24, 2020

James W. Johnston
General Counsel
Texas Board of Nursing

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

Re: The Texas Board of Nursing proposed amendments to 22 Tex. Admin. Code §217.23, relating to Balance Billing Dispute Resolution, as published in the Nov. 27, 2020 edition of the Texas Register

Dear Mr. Johnston:

On behalf of the Texas Medical Association (TMA) and its more than 53,000 physician and medical student members, thank you for the opportunity to submit comments on the Texas Board of Nursing (BON)'s proposed amendments to 22 Tex. Admin. Code §217.23, relating to Balance Billing Dispute Resolution, as published in the Nov. 27, 2020 edition of the Texas Register.

TMA agrees with BON's approach of adopting its own rules implementing the notice and disclosure exception to SB 1264's prohibition on balance billing and expressly limiting those rules to providers within its jurisdiction. This ensures that the agency is appropriately utilizing its regulatory authority.

Although we do not agree with all of the Texas Department of Insurance (TDI)'s rules implementing SB 1264 (and have jurisdictional concerns related to those rules), we also appreciate the BON closely tracking TDI's rule language in its proposed rules. As the BON may know, the Texas Medical Board previously stated (in a December 2019 press release) that it expects its licensees to comply with TDI's rules. Thus, the BON's approach of tracking TDI's rules ensures consistent application of the law among the various agencies charged with regulating out-of-network physicians and providers subject to SB 1264's requirements.

We do, however, ask for clarification on one point. In proposed 22 Tex. Admin. Code §217.23(d), the BON states the following regarding its disciplinary authority under Texas Insurance Code §752.0003:

> (d) Complaint Investigation and Resolution. The Board is authorized under the Insurance Code §752.0003 to take disciplinary action against a licensee that violates a law that prohibits the licensee from billing an insured, participant, ***facility***, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition. … (Emphasis added).

This proposed language closely tracks the language of Insurance Code §752.0003 with one notable exception: it adds the word "facility" into the litany of insured, participant and enrollee. From the context of the rule and a review of the rule preamble, it is unclear why the BON has added this term into the statutory disciplinary language. We, therefore, ask that the BON clarify the basis and intent of this addition.

Once again, the Texas Medical Association thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact me or following staff of the TMA: Kelly Walla, Associate Vice President and Deputy General Counsel at kelly.walla@texmed.org; or Clayton Stewart, Director, Legislative Affairs at clayton.stewart@texmed.org .

Respectfully,

Diana Fite, MD
President, Texas Medical Association

Attachment “B”

Summary of Comments Received

General Comment

A commenter representing Quest Diagnostics states that it applauds the state’s focus on the important issue of surprise and balance billing, but proposes minor amendments to the regulations to make them even stronger and effective. Specifically, the commenter recommends setting a minimum required payment to out-of-network providers of 150% of the Medicare rate. The commenter states that, while it is important to protect patients from receiving surprise bills, it is also important to ensure that providers, particularly clinical labs, receive fair and reasonable reimbursement for the services they perform.

Agency Response to Comment: The Board declines to make the requested change. The Board does not find that SB 1264 grants it statutory authority to establish required payments for out-of-network providers.

§217.23(d)

A commenter representing the Texas Medical Association states that the language of subsection (d) closely tracks the language of the Insurance Code §752.0003, except for the addition of the word ‘facility’ in the subsection. The commenter requests that the Board clarify the basis and intent of this additional term.

Agency Response to Comment: The Board has removed the term ‘facility’ from the rule text as adopted.

Attachment “C” (text recommended for deletion is highlighted below)

§217.23. Balance Billing Notice and Disclosure Requirements.

(a) Purpose. The purpose of this section is to implement the requirements of the Insurance Code §§1271.157, 1271.158, 1301.164, 1301.165, 1551.229, 1551.230, 1575.172, 1575.173, 1579.110, and 1579.111 and the Insurance Code Chapter 1467 and notify licensees of their responsibilities under those sections.

(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. Additionally, 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 benefit plan, as specified in the 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).

(2) Applicability. This section only applies to a covered non-emergency health care or medical service or supply provided on or after January 1, 2020, by:

(A) 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

(B) 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.

Further, this section is limited to providers that are subject to the Board's jurisdiction.

(c) Responsibilities of Licensee.

(1) 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. An enrollee's legal representative or guardian may elect on behalf of an enrollee.

(2) An enrollee elects to obtain a service or supply only if:

(A) 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;

(B) 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

(C) 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 paragraph (3) of this subsection.

(3) If an out of network provider elects to balance bill an enrollee rather than participate in the claim dispute resolution process authorized by the Insurance Code Chapter 1467, the out of network provider or agent or assignee of the provider must

provide the enrollee with the notice and disclosure statement specified in subparagraph (B) of this paragraph 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 referenced in subparagraph (B) of this paragraph.

(A) Each out of network provider, or the provider's agent or assignee, must maintain a copy of the notice and disclosure statement, signed and dated by the enrollee, for four years if the medical service or supply is provided and a balance bill is sent to the enrollee. The provider must provide the enrollee with a copy of the signed notice and disclosure statement on the same date the statement is received by the provider.

(B) The Texas Department of Insurance has adopted Form AH025 as the notice and disclosure statement to be used under this subsection. The notice and disclosure statement may not be modified, including its format or font size, and must be presented to an enrollee as a standalone document and not incorporated into any other document. The form is available from the Texas Department of Insurance by accessing its website at www.tdi.texas.gov/forms.

(4) A provider who seeks and obtains an enrollee's signature on a notice and disclosure statement under this subsection is not eligible to participate in the claim dispute resolution process authorized by the Insurance Code Chapter 1467. This

prohibition does not apply if the election is defective or rescinded by the enrollee under paragraph (3) of this subsection.

(d) Complaint Investigation and Resolution. The Board is authorized under the Insurance Code §752.0003 to take disciplinary action against a licensee that violates a law that prohibits the licensee from billing an insured, participant, ~~facility,~~ or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition. Licensees may also be subject to additional consequences pursuant to the Insurance Code §752.0002. 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 bad faith participation or has committed a violation of the Nursing Practice Act, the Insurance Code Chapter 1467, or other applicable law, the Board will impose appropriate disciplinary action.