86R SB 1264 (Ban on Balance Billing)
By Senator Kelly Hancock & Rep. Tom Oliverson, MD
Summary by the Texas Society of Anesthesiologists

Quick Summary

The bill prohibits an out-of-network physician, midlevel provider, or facility (defined as a hospital, ambulatory surgical center, birthing center, or free-standing emergency room) from balance billing a patient for any amount beyond the usual and customary initial payment by the carrier, and the payment of copays, coinsurance, and deductibles by the patient for emergency medical services, diagnostic imaging, laboratory services, and associated supplies. It also bans balance billing by an out-of-network physician or midlevel provider for scheduled care at an in-network facility unless the provider obtains a signed acknowledgement by the patient that the provider is out-of-network, and that the patient will be responsible for charges exceeding covered amounts. The provider must provide an estimate of costs for medical services. For amounts beyond the usual and customary, copays, coinsurance, and deductibles a facility may request mediation and a physician or mid-level provider may request arbitration, which is a document review only, to determine the appropriate final payment based on specific criteria.

Applicability

The bill's provisions apply to state-regulated Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), and Preferred Provider Organization (PPO) plans, as well as claims under the administrated HMO and PPO plans for the Texas Employees Retirement System and Teachers Retirement System which supply the health benefit coverage for current and retired employees of the state and and school districts, respectively. It applies to emergency medical care, diagnostic imagining, laboratory services and any associated supplies for these medical services provided by an out-of-network facility, physician, or mid-level provider. It also applies to an out-of-network physician or mid-level provider at an in-network facility who provides medical care, diagnostic imaging, laboratory services and any associated supplies for these medical services. It does not apply to an ERISA Plan which is regulated by the federal government.

This bill is effective for applicable medical bills starting January 1, 2020.

Prior to Service Being Provided

A patient may choose to be treated by an out-of-network physician, provider or facility, which might result in a balance bill for the medical service or associated supply if they sign an acknowledgement that the physician, provider or facility is out-of-network, and accepts responsibility for the potential costs to the patient for the medical service or associated supply 10 days prior to the service being provided. This waiver is not an option for a physician whose group has an exclusive provider contract with an in-network facility. If the patient chooses to go to an out-of-network facility, the physicians at that facility may balance bill.

Initial Payment

A carrier, after confirming coverage and receiving a "clean claim" as defined in statute as being complete with an enumerated list of information, shall pay the physician, provider or facility the usual and customary rate (which for emergency care is defined as the 50th percentile of the maximum allowable amount as provided in their master benefit plan). The payment shall be sent directly to the physician, provider or facility within 30 days of submittal of an electronically submitted clean claim and 45 days for a paper-submitted clean claim. At the

same time the initial payment is sent, the carrier must send an explanation of benefits to the patient and the provider which itemizes the copay, coinsurance, and deductible for which the patient is liable and for which they may be billed and a statement that the patient may not be billed and is not responsible for any additional amount .

Dispute Resolution Request

Within 90 days after receiving an initial payment, an out-of-network physician, midlevel provider or facility may apply for assistance in resolving the remaining disputed amount after the initial payment and itemized cost sharing amounts identified in the explanation of benefits. The request may be submitted through an online portal on the Texas Department of Insurance's (TDI) website. Once the dispute resolution process has been requested, the requestor must notify the other party in writing. Fees for the process are split between the carrier and the health care provider. Both parties must participate in an informal teleconference, arranged by the carrier, within 30 days to attempt resolution of the claim.

Facility Mediation

If an out-of-network facility and a carrier cannot settle a claim for emergency care or mutually agree on a mediator within 30 days of the initial request for dispute resolution, the facility will notify TDI, which will choose a mediator from an approved list of mediators. Mediation shall be held no later than the 180th day (6 months) from the request for dispute resolution with a goal to reach an agreement between parties on the final payment. The mediator must submit a report within 45 days after the mediation, stating that the dispute either was or was not resolved. If there was no agreement, a party may file a civil action within 45 days after the mediator's report is filed to determine the payment.

Physician and Midlevel Provider Arbitration

If an out-of-network physician or midlevel provider cannot settle a claim for emergency care or scheduled care at an in-network facility within 30 days after invoking the dispute resolution process and the parties cannot mutually agree on an arbitrator, the provider may notify TDI, which will choose an arbitrator from a list of approved arbitrators. Arbitrators shall perform a document review (there is no discovery) to determine the reasonable payment based on:

- Fees paid to that out-of-network Provider for the same service/supplies in out-of-network situations;
- Fees paid by the carrier for the same services to other out-of-network Providers in the same region;
- Level of training, education, and experience of out-of-network Provider;
- Out-of-network Provider's billed charges for out-of-network services;
- Circumstances and complexity of the particular case;
- Patient's characteristics;
- The 80th percentile of billed charges in the geozip according to a benchmarking database selected by TDI;
- The 50th percentile of rates in the geozip according to a benchmarking database selected by TDI;
- The history of network contracting between the parties;
- The historical data for the 80th and 50th percentiles; and
- An offer made by either party in the informal teleconference.

Arbitrators will provide a written decision within the 51st day arbitration is requested and shall choose either:

- The initial billed charge;

- The initial payment;
- A revised billed charge to correct a billing error or an increase in payment in the appeal process; or
- An offer made in the informal teleconference.

Not later than the 45th day after the arbitrator's decision , either party may file suit to determine whether the arbitrator's decision is proper based on a substantial evidence standard of review, which means the court may consider only the documents submitted to the arbitrator and the criteria by which the decision was required to be made to determine whether the arbitrator's decision is supported by the evidence. If so, the decision will be affirmed.

Bundling of Physician or Midlevel Provider Claims

In order to prevent the cost of splitting the dispute resolution fee from being a financial barrier for claims with small denominations in dispute, TDI shall adopt rules which allow the bundling of claims for amounts in dispute for no more than a total amount of $5,000 for a single arbitration, as long as the bundled disputed claims are between the same carrier and a single provider.

Diagnostic Imaging and Laboratory Services

Diagnostic imaging and laboratory services are listed in both the mediation and arbitration portions of the bill and would depend on whether a facility or an individual physician or provider submitted the bill as to which route it would take in dispute resolution.

Enforcement

The Texas Department of Insurance, the Texas Medical Board, the Texas Department of Health and Human Services, as well as any other regulatory agency for a licensed health care provider may impose administrative penalties against a licensee for failure to comply with the provisions of this process or failure to participate in good faith. If the regulatory agency finds a pattern of knowingly violating the provisions of this process, the regulatory agency, in addition to administrative penalties, may refer the case to the Texas Attorney General, who may seek an injunction against the licensee and may recover any costs and expenses related to the filing.

Regulatory Requirements

Texas Department of Insurance shall:

- Choose a benchmarking database which is not affiliated with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider or any other conflict of interest. The benchmarking database must identify percentiles of billed charges by providers and in-network contract rates for carriers in geographical areas as small as a geozip – defined as an area that includes all zip codes with identical first three digits.
- Establish an online portal to request mediation or arbitration to resolve disputes between carriers and health care providers for balance bills.
- Maintain a list of approved mediators and arbitrators for dispute resolution of balance bills.
- Adopt rules for bundling.

All regulatory agencies for an affected licensee, including a carrier:

- Adopt rules to implement this process and for enforcement of its provisions.