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TEXAS' PROHIBITION ON BALANCE BILLING: WHAT NOW?

by Rachel Freeman and Jenny Givens
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In its most recent session, the Texas Legislature passed S.B. 1264 in an effort to protect patients from surprise medical bills when the patient does not have a choice regarding their medical provider (the Act). While the Act generally prohibits out-of-network providers from balance billing patients for covered services when the patients are enrolled in certain health benefit plans, the Act provides a narrow exception for situations where a patient receiving non-emergency services has freely chosen a doctor that is out-of-network with the patient's insurance provider. In these situations the patient can sign a balance billing waiver acknowledging that the patient may have to pay more for services rendered by the out-of-network provider.

Emergency Waiver Regulations

On December 18, 2019, the Texas Department of Insurance (TDI) issued regulations on an emergency basis interpreting the Act's provisions relating to balance billing waivers (the Waiver Regulations). The Waiver Regulations went into effect January 1, 2020. Initially, the Texas Medical Board (TMB) was given the responsibility to issue the Waiver Regulations. The TMB interpreted these requirements broadly and in response, consumer protection advocates argued that the TMB was creating a loophole and ultimately Lieutenant Governor Dan Patrick issued a statement admonishing the TMB for attempting to circumvent the legislation. Following these events, the TMB relinquished rulemaking authority to the TDI. As emergency rules, the Waiver Regulations may not be in effect for more than 180 days, but during this time TDI has stated its intent to issue the same or similar rules under the normal rulemaking process. Stakeholders are encouraged to participate in the comment period once this process is initiated.

Scope of the Act and Waiver Regulations

Before moving to the content of the Waiver Regulations, it is important to note the scope of the Act. First, to fall within the Act's balance billing prohibition, the service or supply being provided to the patient must be one that is covered by the patient's benefit plan (Covered Service). For example, if the patient's benefit plan does not provide coverage for genetic diagnostic testing, then an out-of-network laboratory may bill the patient without obtaining a balance billing waiver. Second, the patient must be enrolled in a health benefit plan that is regulated under the Act (an Enrollee). Once it has been determined that a Covered Service is being provided to an Enrollee, then the question becomes whether the out-of-network health care provider rendering the service or supply is permitted to utilize the balance billing waiver under the Waiver Regulations (OON Provider).

> *Who is an Enrollee?* The Act's prohibition and associated Waiver Regulations only apply to individuals who have coverage through one of the state employee health plans, the teacher retirement system and individuals with state-regulated insurance plans. Enrollees in state-regulated plans can be identified by their insurance card, which will have "DOI" or "TDI" printed on it.[1] FAQs published on the TDI's website clarify that the Act does not apply to self-funded employer-sponsored health plans.

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[1] TDI has provided examples, which are *available at: https://www.tdi.texas.gov/consumer/insurance-card-examples.html.*

Who is an OON Provider? The Waiver Regulations specify three categories of OON Provider who, should they choose to balance bill an Enrollee, must utilize the balance billing waiver when Covered Services are provided:

(1) *Facility-Based Providers* – An out-of-network facility-based provider, when the service or supply is provided at a health care facility that is an in-network provider. Interestingly, "facility-based provider" is broadly defined to include not just traditional facility-based providers like radiologists and anesthesiologists, but any physician, licensed health care practitioner or other health care provider who provides health care or medical services to patients of an ambulatory surgical center, a birthing center, a hospital or a freestanding emergency medical care facility.

(2) *Diagnostic Imaging Providers* – An out-of-network diagnostic imaging provider, when the service or supply is provided in connection with a health care or medical service or supply provided by an in-network provider. "Diagnostic imaging provider" includes a provider who performs a diagnostic imaging service (i.e., MRI, CT, PET or hybrid technology that combines the foregoing modalities) on a patient for a fee, or interprets images produced by these imaging modalities.

(3) *Laboratory Service Providers* – An out-of-network laboratory service provider, when the service or supply is provided in connection with a health care or medical service or supply provided by an in-network provider. "Laboratory service provider" means an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made, or a physician who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.

Prohibition on Balance Billing for Non-Emergency Services or Supplies

Under the Act and Waiver Regulations, an OON Provider may not "balance bill" an Enrollee who is receiving a non-emergency Covered Service, and such Enrollee does not have financial responsibility for a balance bill, unless the Enrollee elects to obtain the non-emergency Covered Service from the OON Provider knowing that the provider is out-of-network and the Enrollee may be financially responsible for a balance bill. If the OON Provider chooses to balance bill, then the provider is no longer eligible to participate in the dispute resolution processes with the insurance provider under the Act. While this article focuses on the Waiver Regulations' impact on non-emergency care, the Act also prohibits an OON Provider from balancing billing an Enrollee who receives emergency care.[2]

Patient Election to Use an OON Provider

An Enrollee is considered to have knowingly elected to receive non-emergency Covered Services from an OON Provider if:

(1) The Enrollee has a meaningful choice between an in-network provider and the OON Provider. The Enrollee does not have meaningful choice if the OON Provider was selected or assigned by another provider or health benefit plan issuer or administrator;

(2) The Enrollee is not coerced by a provider, health benefit plan issuer or administration when making the election. A provider engages in coercion if the provider charges (or attempts to) a nonrefundable fee, deposit or cancellation fee for the service or supply prior to the enrollee's election; and

(3) The OON Provider (or their agent) provides written notice and disclosure to the enrollee and obtains the enrollee's written consent (i.e., obtains an executed balance billing waiver).

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[2] Emergency care means "health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the person's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of a bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus." Tex. Ins. Code § 1301.155.

Content of Balance Billing Waiver

TDI has adopted Form AH025 as the form balance billing waiver, which can be accessed on TDI's website. This form may not be modified by the OON Provider in any way, and must be presented to the Enrollee as a standalone document (i.e., not be incorporated into any other document).

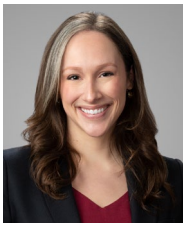
Timing of Balance Billing Waiver

An OON Provider must give the Enrollee the balance billing waiver prior to scheduling the Covered Service. To be effective, the balance billing waiver must be signed and dated by the Enrollee no less than 10 business days before the date the Covered Service is performed or provided. The Enrollee has the right to withdraw his or her acceptance of the balance billing waiver within five business days from the date the Enrollee signs the waiver. The OON Provider must give a copy to the enrollee on the date the waiver is signed, and must maintain a copy of the signed waiver for four years.

Practical Implications for OON Providers

While the Waiver Regulations may be subject to change due to their emergency rule status, OON Providers need to be aware that the prohibitions in the Act and the Waiver Regulations apply to medical services and supplies provided on or after January 1, 2020. If they have not done so already, OON Providers should put processes in place to ensure that Enrollees receiving non-emergency Covered Services are flagged and, if the intent is to balance bill the Enrollee, ensure the Enrollee timely executes the TDI approved balance billing waiver form.

ABOUT THE AUTHORS



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