SUBJECT: Creating arbitration and mediation systems and prohibiting balance billing

COMMITTEE: Insurance — committee substitute recommended

VOTE: *After recommitted:*
7 ayes — Lucio, Oliverson, G. Bonnen, S. Davis, Julie Johnson, Lambert, C. Turner

0 nays

2 absent — Paul, Vo

SENATE VOTE: On final passage, April 16 — 29-2 (Campbell, Schwertner)

WITNESSES: *On House companion bill, HB 3933:*
For — Blake Hutson, AARP Texas; Stacey Pogue, Center for Public Policy Priorities; Mia McCord, Texas Conservative Coalition; Simone Nichols-Segers, National MS Society; Jessica Boston, Texas Association of Business; Jamie Dudensing, Texas Association of Health Plans; Evan Pivalizza, Texas Society of Anesthesiologists, Texas Medical Association; Bay Scoggin, TexPIRG; Don Johnson; (*Registered, but did not testify:* Anna Gu, Children's Defense Fund Texas; Lauren Rangel, Easterseals Central Texas; Christine Yanas, Methodist Healthcare Ministries of South Texas, Inc.; Greg Hansch and Alissa Sughrue, National Alliance on Mental Health Texas; John McCord, NFIB; Adriana Kohler, Texans Care for Children; Angela Theesfeld, Texas Association of Health Underwriters; Deanna Kuykendall, Texas Brain Injury Providers Alliance; Joshua Massingill, Texas Chiropractic Association; Diana Fite, Texas College of Emergency Physicians; Joshua Houston, Texas Impact; Ray Callas, Texas Medical Association, Texas Society of Anesthesiologists; Jenna Courtney, Texas Radiological Society; Michael Grimes, Texas Society of Pathologists; Ware Wendell, Texas Watch; Bradford Holland; Cheryl Johnson)

Against — (*Registered, but did not testify:* Mark Feanny, America's ER; Dan Mays, Consumer Data Industry Association; Daniel Chepkauskas,

Patient Choice Coalition of Texas)

On — John Hawkins, Texas Hospital Association; (*Registered, but did not testify:* Doug Danzeiser, Texas Department of Insurance)

BACKGROUND:

Insurance Code sec. 1467.051 allows an enrollee of a health benefit plan to request mandatory mediation of a settlement of an out-of-network health benefit plan claim if:

- the amount for which the enrollee is responsible to a facility-based provider or emergency care provider, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $500; and
- the health benefit claim is for emergency care or 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.

Sec. 843.336 defines a clean claim as a claim by a physician, provider, or institutional provider that complies with all applicable rules and necessary forms. Secs. 1301.103 and 843.338 require certain health benefit plans to respond to clean claims within 30 days for an electronic claim and within 45 days for a nonelectronic claim.

Sec. 1467.101 defines bad faith mediation as failing to participate in the mediation, failing to provide information the mediator believes is necessary to facilitate an agreement, or failing to designate a representative participating in the mediation with full authority to enter into any mediated agreement. Bad faith mediation is grounds for imposition of an administrative penalty by the regulatory agency that issued a license or certificate of authority to the party who committed the violation.

DIGEST:

CSSB 1264 would prohibit balance billing to health benefit plan enrollees, expand the Texas Department of Insurance (TDI) mediation program between health benefit plans and out-of-network providers that were

facilities, create an arbitration system between health benefit plans and out-of-network providers that were not facilities, and require health plans to cover certain out-of-network services at the usual and customary rate.

Definitions. "Arbitration" would be defined as a process in which an impartial arbiter issued a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim.

"Out-of-network provider" would be defined as a diagnostic imaging provider, emergency care provider, facility-based provider, or laboratory service provider that was not a participating provider for a health benefit plan.

Applicability. The bill would apply to a health benefit plan offered by a health maintenance organizations (HMO), a preferred provider benefit plan offered by an insurer, and a health benefit plan other than an HMO.

Balance billing. For a health care service or supply that insurers had to cover, an out-of-network provider could not bill an enrollee for more than an applicable copayment, coinsurance, or deductible under the enrollee's health benefit plan that:

- was based on the amount initially determined payable by the health benefit plan issuer or administrator or, if applicable, a modified amount as determined under the issuer's or administrator's internal dispute resolution process; and
- was not based on any additional amount owed to the provider as the result of a formal dispute resolution process.

Health benefit plan issuers or administrators would have to provide written notice in an explanation of benefits provided to the enrollee and the out-of-network provider in connection with a health care service or supply that was subject to required coverage under the bill. The notice would have to include:

- a statement of the billing prohibition;
- the total amount the provider could bill an enrollee under the enrollee's health benefit plan and an itemization of copayments, deductibles, coinsurance, or other amounts included in that total; and
- for an explanation of benefits provided to the provider, information required by insurance commissioner rule advising the provider of the availability of mediation or arbitration, as applicable.

Enforcement. The attorney general could bring a civil action in the name of the state to enjoin the individual or entity from a violation if the attorney general received a referral indicating that an individual or entity, including a health benefit plan issuer or administrator, had exhibited a pattern of intentionally violating the prohibition on balance billing. The attorney general could recover reasonable attorney's fees and expenses incurred if the action prevailed.

Agencies that regulated the health care industry also would have to take disciplinary action against entities that violated the prohibition on balance billing. Regulatory agencies could adopt necessary rules to implement the bill and would not be subject to increasing cost requirements.

Mandatory mediation. The insurance commissioner would be required to establish and administer a mediation program to resolve disputes over out-of-network provider charges for providers that were facilities. The commissioner would have to adopt rules necessary for the implementation of the program, including an online mediation request form, and maintain a list of qualified mediators for the program.

Out-of-network providers, health benefit plan issuers, and administrators could request mediation of a settlement of an out-of-network health benefit claim through a portal on TDI's website if:

- there was an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee could not be billed; and

- the health benefit claim was for emergency care, an out-of-network laboratory service, or an out-of-network diagnostic imaging service.

If a person requested mediation, the out-of-network provider and the health benefit plan issuer or administrator would have to participate in the mediation.

The bill would require a mediator to be approved by the insurance commissioner, rather than the chief administrative law judge, and the insurance commissioner would have to immediately terminate the approval of a mediator who no longer met the requirements of the bill.

If the parties did not select a mediator by mutual agreement on or before the 30th day after the date the mediation was requested, the party requesting the mediation would have to notify the insurance commissioner, who would select a mediator from the list of approved mediators.

The person requesting mediation would have to provide written notice on the date the mediation was requested in the form and manner provided by insurance commissioner rule to TDI and each other party.

Right to receive payment and file action. Out-of-network providers would have the right to a reasonable payment from an enrollee's health benefit plan for covered services and supplies provided to the enrollee for which the provider had not been fully reimbursed. Within 45 days of the mediator's report, either party to a mediation for which there was no agreement could file a civil action to determine the amount due to an out-of-network provider. Parties could not bring a civil action before the conclusion of the mediation process.

Within 45 days of the mediation's conclusion, the mediator would have to report to the insurance commissioner and the Texas Medical Board the names of the parties to mediation and whether they reached an agreement.

Mandatory arbitration. The insurance commissioner would have to establish and administer an arbitration program to resolve disputes over out-of-network provider charges for providers that were not facilities. The commissioner would have to adopt rules necessary for the implementation of the program, including an online mediation request form, and maintain a list of qualified arbitrators for the program.

The only issue an arbitrator could determine would be the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider. The determination would have to take into account several factors specified in the bill, including:

- whether there was a gross disparity between the fee billed by the out-of-network provider and fees paid to the out-of-network provider for the same services to other enrollees and fees paid by the health benefit plan issuer to reimburse similarly qualified providers for the same services in the same region;
- the out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees; and
- the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported in the benchmarking database.

Within 90 days of the date an out-of-network provider received the initial payment for a health care or medical service or supply, the out-of-network provider or the health benefit plan issuer or administrator could request arbitration of a settlement of an out-of-network health benefit claim through a portal on TDI's website if the claim met certain requirements as specified in the bill.

If a person requested arbitration, the out-of-network provider and health benefit plan issuer or administrator, as appropriate, would have to participate in the arbitration. The person who requested the arbitration would have to provide written notice on the date the arbitration was requested to TDI and each other party.

All parties would have to participate in an informal settlement teleconference within 30 days of the date on which the arbitration was requested.

The insurance commissioner would have to adopt rules providing requirements for submitting arbitration in one proceeding. The rules would have to meet certain requirements as specified in the bill.

Out-of-network providers, health benefit plan issuers, or administrators could not file suit for an out-of-network claim until the conclusion of arbitration on the issue of the amount to be paid in the out-of-network claim dispute. Arbitrations conducted under the bill would not be subject to civil practices and remedies law governing alternate methods of dispute resolution.

Selection and approval of arbitrators. If the parties did not select an arbitrator by mutual agreement within 30 days of the date that the arbitration was requested, the party requesting the arbitration would have to notify the insurance commissioner, who would select an arbitrator.

In approving an individual as an arbitrator, the insurance commissioner would have to ensure that the individual did not have a conflict of interest. The insurance commissioner would have to immediately terminate the approval of an arbitrator who no longer met the requirements under the bill.

Procedures. The arbitrator would have to set a date for submission of all information to be considered. Parties could not engage in discovery in connection with the arbitration. On agreement of all parties, any deadline under the bill could be extended. Unless otherwise agreed to by the parties, an arbitrator could not determine whether a health benefit plan covered a particular health care or medical service or supply. Parties would have to evenly split and pay the arbitrator's fees and expenses.

Decision. Within 75 days of the date that the arbitration was requested, an

arbitrator would have to provide the parties with a written decision in which the arbitrator determined whether the billed charge or initial payment made by the health benefit plan issuer or administrator was closest to the reasonable amount for the services or supplies. If the out-of-network provider elected to participate in the internal appeal process of the issuer or administrator before arbitration, the provider could revise the billed charge to correct a billing error, and the health benefit plan issuer or administrator could increase the initial payment. The arbitrator would select that billed charge or initial payment as the binding award amount.

An arbitrator could not modify the binding award amount. An arbitrator would have to provide written notice of the reasonable amount for the services or supplies and the binding award amount. If the parties settled before a decision, the parties would have to provide written notice of the amount of the settlement. TDI would have to maintain a record of the notices.

An arbitrator's decision would be binding. Within 45 days of the decision, a party not satisfied with the decision could file an action to determine the payment due, in which case the court would have to determine whether the arbitrator's decision was proper based on a substantial evidence standard of review. Within 10 days of the arbitrator's decision or a court's determination, a health benefit plan issuer or administrator would have to pay to an out-of-network provider any additional amount necessary to satisfy the binding award or the court's determination, as applicable.

Bad faith participation. The same standards and penalties for bad faith mediation would apply to conduct in an arbitration under the bill.

Required coverages. Under the bill, certain health benefit plans would have to cover emergency care at the usual and customary rate or an agreed rate. They also would have to cover care from a facility-based provider, diagnostic imaging, and laboratory services at the usual and customary rate or an agreed rate if the provider performed the service at a health care facility that was a participating provider. The usual and customary rate would be the relevant allowable amount as described by the master benefit

plan document or policy.

The bill would not apply to a nonemergency health care or medical service that an enrollee elected to receive from an out-of-network provider if the out-of-network provider provided the enrollee with written disclosure that explained that the provider did not have a contract with the enrollee's health benefit plan, disclosed projected amounts for which the enrollee could be responsible, and disclosed the circumstances under which the enrollee would be responsible for those amounts.

Clean claims. Health maintenance organizations would have to act on a clean claim related to a health care or medical service or supply required to be covered under the bill as if the out-of-network provider was a participating physician or provider. Insurers would have to act on a clean claim related to a health care or medical service or supply as if the out-of-network provider was a preferred provider. Administrators would have to act on a clean claim related to a health care or medical service or supply as if the out-of-network provider was a preferred provider and the administrator was an insurer.

Benchmarking database. The insurance commissioner would have to select an organization to maintain a benchmarking database that contained information necessary to calculate, with respect to a health care or medical service or supply, for each geographical area in the state:

- the 80th percentile of billed charges of all physicians or health care providers who were not facilities; and
- the 50th percentile of rates paid to participating providers who were not facilities.

The insurance commissioner could not select an organization that was financially affiliated with a health benefit plan issuer to maintain the database.

Study. TDI would have to conduct a study on the impacts of the bill on Texas consumers and health coverage in the state each biennium and

submit a written report on the results and findings to the Legislature by December 1 of each even-numbered year. The study would have to include information on trends in billed amounts and amounts paid for health care and medical services, network participation, number of complaints, the effectiveness of the claim dispute resolution process, and other areas as specified in the bill.

TDI would have to collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration. TDI would have to collect data quarterly from a health benefit plan issuer or administrator to conduct the study and could use any reliable external resource to acquire information reasonably necessary to prepare the report.

Appropriations. TDI, the Employees Retirement System of Texas, the Teacher Retirement System of Texas, and any other state agency subject to the bill would be required to implement a provision of the bill only if the Legislature appropriated money specifically for that purpose. If the Legislature did not appropriate money, the agencies would be permitted, but not required to, implement the bill with other available appropriations.

The bill would take effect September 1, 2019, and would apply to a health care or medical service or supply provided on or after January 1, 2020.

SUPPORTERS SAY:

CSSB 1264 would protect Texans from surprise medical billings. When patients cannot choose their medical care providers, such as in emergency situations, they may unknowingly get care out of their network because of an out-of-network physician at an in-network facility or because they were transported to the nearest facility for emergency care. When an insurance company fails to cover the cost of the service, the provider then bills the patient for the remaining balance and it is the patient's responsibility to contest the bill. This balance billing would be prohibited under CSSB 1264, relieving consumers of these surprise medical bills. Instead of billing the patient, the provider would have to go through a process of mediation or arbitration with the insurer until a price was agreed upon.

Requiring the mediation or arbitration processes to take place between the insurer and provider would relieve consumers of the stress, confusion, and difficulty of having to navigate the mediation process and protect consumers from unexpected high costs associated with care that they either had no choice in receiving or that they thought was covered under their health insurance.

The bill also would incentivize compliance by allowing the attorney general to bring a civil action against any entity that violated the prohibition on balance billing. Regulatory agencies also would be required to enforce the prohibition, giving the bill the penalties necessary for it to be successful.

The bill would use "baseball-style arbitration," which requires each party to suggest a price they considered to be reasonable to the arbiter, who then would choose the more reasonable rate between the two. In other states, this style of arbitration has led to a decrease in both physician charges and out-of-network billing.

The study required under the bill would provide lawmakers, consumers, and agencies with the information necessary to gain a deeper understanding of the value of health plans. By allowing billing rates to be worked out through the mediation and arbitration processes rather than assigning a standard, the bill would ensure that the widest possible number of stakeholders benefited from the bill.

OPPONENTS SAY:

CSSB 1264 would not solve the central cause of surprise medical billing because it would not create a standard billing rate for services. Instead, the bill should define a usual and customary rate as no more than the 80th percentile of billed charges of all physicians or health care providers in the region. Without defining rates, the arbiters, insurance companies, and providers would have no reference point for what a reasonable charge would be and too many claims would have to be arbitrated through this system. Providing a reference point would allow for fewer claims and a more transparent and streamlined system.

OTHER OPPONENTS SAY:

Rather than the 80th percentile of billed charges, CSSB 1264 should set rates that were based upon other government rates, such as Medicaid. Using government rates as a starting point would mean a fairer rate for all parties involved.

NOTES:

According to the Legislative Budget Board, the bill would have a negative impact of $10.5 million to general revenue related funds through fiscal 2020-21.

CSSB 1264 was reported favorably without amendment from the House Committee on Insurance on May 6, placed on the General State Calendar for May 17, recommitted to committee, and reported favorably as substituted on May 16.