AARP Real Possibilities

CENTER for PUBLIC POLICY PRIORITIES

November 26, 2019

Ms. Rita Chapin
Texas Medical Board
333 Guadalupe Street
Austin, Texas 78701

Via: rules.development@tmb.state.tx.us

RE: Comments on proposed 22 TAC §165.7

To whom it may concern:

AARP Texas and the Center for Public Policy Priorities appreciate the opportunity to provide input in the rulemaking process for Senate Bill 1264. As you know, we strongly support the bill and believe it provides long-needed and meaningful protections against surprise medical bills for patients with health plans overseen by the state.

We have three serious concerns with the rule as proposed:

1. The waiver process should be a narrow exception to the default of a ban on surprise medical billing. As proposed, however, the exception swallows the rule, removing much of the intended patient benefit. We assume this was not the intention.

2. Providers who are assigned to patients are allowed to ask patients to waive their protections, even though their patient will not have a reasonable alternative to signing the waiver that will allow them to get needed care timely. Patients with no meaningful alternative will feel coerced.

3. The waiver forms themselves were not designed to be understandable to patients.

This rule gives patients who don't get to pick their providers two bad choices: agree to pay more than they have to under law or risk not getting the health care they need timely. During the TMB proposed rule deliberation one board member asked why a patient would ever sign this form. That question deserves some thought. Given that the opt-out appears designed to benefit physicians and insurers at the expense of patients, it is hard imagine why a patient would sign the opt-out form, especially from an assigned physician, unless they do not understand the confusing form or they are afraid they won't get needed health care on a timely basis without signing.

The opt-out benefits physicians, giving them options on how to increase payments. It allows physicians, on a patient-by-patient basis, to decide whether to use arbitration to determine payment amounts or instead, to first ask the patient directly to pay the balance bill. If the patient does not agree to pay, the physician maintains the ability to seek additional compensation through arbitration. The opt-out also benefits insurers. It removes all new responsibilities assigned to insurers in SB 1264, relieving them of

the requirements to: (1) pay at the usual and customary rate, (2) participate in arbitration, and (3) pay additional amounts to the physician depending on the arbitrator's ruling.

We do not believe that the opt-out process *as proposed* is consistent with the intent of the law. SB 1264's purpose is to close loopholes, not create them. Loopholes and exceptions in Texas' system for surprise billing dispute resolution had frustrated consumers and legislators for a decade. SB 1264 sought to finally create a strong consumer protection across all health plans the state can reach and all health care encounters that can lead to surprise bills.

We have several recommendations on how to make the rule consistent with the statute and better protect patients and consumers.

1. The proposed rule should expressly prohibit balance billing and state the limitations of patient financial responsibility created by SB 1264.

The rule does not explicitly prohibit balance billing in the surprise billing scenarios laid out in S.B. 1264, but should. That is the central patient protection in the bill. The rule should set out that if a physician receives an Explanation of Benefits from a health plan as required in TDI proposed rule 28 TAC §21.5040, s/he may not attempt to collect payment beyond a patient's applicable in-network copayment, coinsurance, and deductible under the enrollee's health care plan as spelled out in the EOB.

There should be no question that TMB can and will enforce the patient billing protections in SB 1264 and that violations of that law by physicians fall under 22 TAC §190.8(2) or another appropriate TMB violation guideline. Enforcement has proven challenging elsewhere. Mississippi banned balance billing in 2013, but the law is not well known, balance bills are still being sent, and enforcement has been a challenge.[1] According to a news report, both the state's Department of Insurance and Attorney General's office say they can help parties mediate disputes about out-of-network balance bills but they cannot enforce the state's ban on balance billing.[2] We do not want a similar outcome in Texas.

> **Recommendation**: add a new subsection §165.7(c) as follows:
>
> (c) In accordance with Texas Insurance Code requirements, an out-of-network provider who receives an Explanation of Benefits as described in 28 TAC §21.5040 shall not bill an enrollee for health care services or supplies, and the enrollee does not have financial responsibility for, an amount other than the applicable in-network copayment, coinsurance, or deductible under the enrollee's health care plan as listed in the Explanation of Benefits.

[1] Anna Wolfe, "Mississippi health care providers breaking the law with large medical bills that patients don't have to pay, report finds," *Mississippi Today*, March 11, 2019, https://mississippitoday.org/2019/03/11/mississippi-health-care-providers-breaking-the-law-with-large-medical-bills-that-patients-dont-have-to-pay-report-finds/

[2] Anna Wolfe, "You might not have to pay that medical bill. Here's the law you need to know." *Mississippi Clarion Ledger,* June 15, 2018, https://www.clarionledger.com/story/news/politics/2018/06/15/you-might-not-have-pay-bill-but-you-have-know-law/682697002/

2. To align with the statute, the rule must not require physicians to give the opt-out form to patients who receive nonemergency care.

The rule as discussed in the October 18, 2019 Texas Medical Board meeting and the proposed rule as published appear very different. In the discussion, Dr. Zaafran indicated that the opt-out form should be an exception, something that out-of-network providers choose to use infrequently. But as published, the proposed rule *requires* all out-of-network providers giving nonemergency care to give the opt-out form to patients. It says "an out-of-network provider *shall* provide [the opt-out form]."

This turns the patient protection in SB 1264 on its head. In statute, patients receiving health care subject to SB 1264 are protected from balance billing as the default; however, there is a narrow exception for patients to agree in advance and in writing to paying a balance bill. The proposed rule instead makes using the opt-out form to ask a patient to pay the balance bill the default, circumventing the billing protection for patients, the usual and customary payment standard for insurers, and the use of arbitration by insurers and physicians to settle disputes. The proposed rule does not appear to give a provider discretion to let the SB 1264 balance billing protection be the default position. We assume this was not the intention; it needs to be corrected.

Recommendation: Modify proposed §165.7(c) as follows:

(d) ~~(c) In accordance with Texas Insurance Code requirements,~~ Notwithstanding subsection (c), an out-of-network provider who receives an Explanation of Benefits as described in 28 TAC §21.5040 may bill an enrollee for amounts other than the applicable in-network copayment, coinsurance, or deductible under the patient's health care plans only if the out-of-network provider gives ~~shall provide~~ written notice and disclosure to ~~an~~ the enrollee prior to providing nonemergency health care or medical services to the enrollee and the enrollee elects in writing to receive the services at the disclosed amount. The required notice and disclosure must be in writing and provided to the enrollee by the out-of-network provider or agent or assignee of the out-of-network provider, in a form that substantially complies with the board approved notice and disclosure statement and Texas Insurance Code requirements.

3. Prohibit the use of the waiver form by physicians who are *assigned* to patients, where the patient has no meaningful choice or alternative. Also, ensure that patients cannot be asked to waive their SB 1264 protections while they are hospitalized.

When a patient has no meaningful alternative to get needed health care on a timely basis other than agreeing to the waiver, the patient will be put under duress and feel coerced into signing. TMB can and should design a waiver process that does not put patients in this position.

TMB should prohibit the use of the waiver by physicians who are assigned to patients, where patients have no meaningful choice or available alternative. The statutory language limits application of the waiver to "a health care or medical service that the enrollee *elects* to receive…" (emphasis added). Patients cannot make an *election* to see an out-of-network provider when they had no choice in providers. Nor should they be considered to have *elect*ed an assigned out-of-network provider at a higher cost when they have no ability to choose an alternate in-network provider that will not delay needed and/or scheduled care or cause duress in decision making.

Application of the opt-out should be limited only to a patient who proactively chooses an out-of-network provider over an available in-network one, with full, advance information on financial implications. TMB should also expressly prohibit out-of-network physicians from asking a patient to opt-out of SB 1264 protections while in an inpatient setting.

The only way the opt-out could benefit patients is if it allowed a patient access to a specific provider that they have proactively chosen and who would otherwise not agree to treat the patient without the ability to balance bill. As proposed, however, the waiver benefits both physicians and insurers while harming patients who lack realistic alternatives.

> **Recommendation**: add a new subsection §165.7(e) as follows:
>
> <u>(e) A physician may only present a notice and disclosure form and ask an enrollee to make an election if the enrollee has a reasonable alternate way to get needed health care on a timely basis if they were to decline services at the disclosed price. Physicians may not present a notice and disclosure form and ask an enrollee to make an election if:</u>
>
> > <u>(1) the physician was assigned to the enrollee and the enrollee had no choice in providers; or</u>
> > <u>(2) the enrollee is an inpatient at a health care facility.</u>
>
> **Recommendation:** Add two new attestations to the wavier form, so patients can affirm that: (1) the out-of-network provider is one that the patient choose, not one assigned to them, and (2) that the patient is not hospitalized when the form was presented or signed.

4. **Maintain the requirement that the opt-out notice be given *prior to* scheduling. Do not shorten the timelines in proposed in §165.7(d). Any changes that shorten the notice/opt-out period would harm patients by reducing realistic alternatives for getting needed care.**

When combined with our previous recommendation limiting the use of the waiver, the timelines in the rule provide an appropriate guardrail. We know physician groups have advocated to the Texas Department of Insurance that no timeline apply. **TMB should not in any way weaken or shorten the timeline as proposed §165.7(d).** Patients undergoing nonemergency procedures must often rearrange their lives to accommodate the procedure and recovery, including getting time off of work, arranging for alternate child care, etc. On top of that, patients are dealing with pain and worry associated with illness or injury. Patients who need health care and are balancing these stressors will not have a realistic alternative to signing the waiver, even if they do not want to, if it is not given both prior to scheduling a procedure and at least 10 business days out.

If there is ever an appropriate time to ask a patient to agree to pay more than is required under law, it is *before* a procedure is ever scheduled <u>with the treating physician and facility</u>, when the patient may be able to research other options and before they have rearranged their lives to accommodate a procedure. The prior-to-scheduling requirement should be maintained and clarified to ensure that it considers the scheduling by the patient with the treating physician and/or facility, not any subsequent scheduling of ancillary providers. Similarly, it is appropriate to prohibit waivers if the procedure is scheduled and the form presented less than 10 business days before a procedure; though even with a 10-business day window, individual circumstances may lead some patients to feel coerced into accepting the waiver to ensure needed care. **There would be no patient benefit in**

shortening/weakening the proposed timeline. Shortening the timeline or otherwise weakening this proposal would necessarily place more duress on ill or injured patients in need of care who are likely experiencing pain and/or anxiety. A shorter timeline will give physicians more options, but remember, out-of-network physicians who cannot present a waiver due to the timeline are still protected through the arbitration process created under SB 1264.

> **Recommendation**: Modify §165.7(d) as follows:
>
> (f) ~~(d)~~ To be effective, a ~~The enrollee must be provided the~~ notice and disclosure statement must be given to the enrollee by the out-of-network provider prior to the scheduling of the nonemergency health care or medical service by the treating physician and facility and no less than ten business days prior to the date the nonemergency health care or medical service is performed. The enrollee must be given at least five business days to consider whether to ~~accept the~~ elect to pay the disclosed amounts in the notice and disclosure statement and may not agree prior to three business days after the notice and disclosure statement was provided. The notice and disclosure statement must be signed and dated by the enrollee no less than five business days prior to the date the service is performed. A provider shall not charge any nonrefundable fee, deposit, or cancellation fee for the procedure prior to the receipt of the signed notice and disclosure statement.

5. **The rule should state that if a provider voluntarily presents an opt-out form and a patient agrees to opt-out, that the physician waives his/her right under SB 1264 to: (1) receive payment at the "usual and customary rate," (2) receive payment according to the timelines in the bill, and (3) elect arbitration as a means to seek additional payment from the health plan**.

The statute makes clear that both the patient *and* the provider will lose important rights under SB 1264 if a provider elects to present the opt-out form and the patient agrees to pay the disclosed balance bill amount. Physicians need to know what these tradeoffs are before asking a patient to pay more than they need to. Not only does the rule fail to spell out the rights the physician loses, the opt-out form does not give this needed information to the provider.

> **Recommendation:** Add a new subsection that spells out that if an out-of-network provider chooses to present an opt-out form to a patient and the patient accepts the opt-out, that the physicians waives his/her right under SB 1264 to: (1) receive payment at the "usual and customary rate," (2) receive payment according to the timelines in the bill, and (3) elect arbitration as a means to seek additional payment from the health plan.

6. **Require that the out-of-network physician or his/her representative explain both waiver forms in-person with the patient when they present them.**

On the proposed waiver form in Figure 1: 22 TAC §165.7(j) item number 6, the patient must attest that the provider explained the form in Figure 2 to the patient *in-person*. The rule fails to require an in-person explanation of either form. An in-person review and explanation is an important patient protection. Giving information in writing and then reviewing it orally can help increase understanding of complex information. Required in-person review will also raise awareness of the form and the election the patient is making, hopefully preventing the waiver from being "lost" in the middle of a stack of other forms. Finally, it will give the patient a chance to ask questions and get clarification.

Recommendation: Add a new subsection that requires the out-of-network provider or his/her representative explain both waiver forms, 22 TAC §165.7(j) Figure 1 and Figure 2, *in-person* with the patient when they present them.

7. Require *one* waiver form for *each* out-of-network provider, to reduce confusion and ensure the patient has a way to separately elect or reject services at the disclosed price for each provider, as directed by statute.

The TMB proposed forms provide a way for each out-of-network provider to separately disclose prices by using a separate Figure 2 form for each out-of-network billing provider. However, §165.7(e) allows multiple out-of-network providers to disclose together using one combined Figure 1 waiver form, which contains space to include up to 6 out-of-network billing provider names. There is no way on Figure 1 for a patient to elect to pay a balance bill for her anesthesiologist, but reject that option for her assistant surgeon, or vice versa.

The statute, pasted below with emphasis added, requires the patient to elect the waiver in writing for ***each*** out-of-network provider.

> (d) This section does not apply to a nonemergency health care or medical service:
>
> (1) that an enrollee elects to receive in writing in advance of the service **with respect to each non-network physician or provider providing the service**; and
>
> (2) for which a non-network physician or provider, before providing the service, provides a complete written disclosure to the enrollee that:
>
> (A) explains that the physician or provider does not have a contract with the enrollee's health benefit plan;
>
> (B) discloses projected amounts for which the enrollee may be responsible; and
>
> (C) discloses the circumstances under which the enrollee would be responsible for those amounts.

The easiest way to ensure a patient can make a separate election with respect to each out-of-network provider is to require a separate, singular waiver form and in-person explanation for *each* provider seeking to balance bill. That change is both consistent with statute and will help mitigate some patient and provider confusion with the two forms, as proposed.

Recommendation: Strike proposed subsection (e). Combine Figure 1 and Figure 2 into one form. Require each out-of-network provider seeking to balance bill to present the single waiver form to the patient.

8. The rule should define specifically what is included and excluded in "projected amounts for which the enrollee may be responsible" to ensure patients receive meaningful disclosure and can make an informed choice. The patient should be told the projected amount they will actually owe to the provider excluding other amounts that are not the patient's responsibility.

Patients should not be asked to waive consumer protections without a high standard set for meaningful and actionable information in the cost disclosure. Sec. 165.7(g)(2) requires that the waiver form "disclose projected amounts for which the enrollee may be responsible." **Patients cannot make an informed choice to accept or reject the waiver if they do not first know clearly the projected amount they must pay to the out-of-network provider**. In addition, providers cannot accurately and consistently give cost information to patients without further guidance in the rule and clear instructions on the waiver form.

To be consistent with the statute's appropriate focus on the patient's responsibility, the only price information on the waiver form must be a good faith projection of what the patient will ultimately owe to the provider that takes into account: (1) the allowed amount determined by the plan, (2) whether some or all of the allowed amount will be paid directly by the plan to the provider or must be charged to the patient because s/he has not met the plan deductible, and (3) whether the provider intends to try to collect his/her full billed charge or some amount less than that. **Simply listing the provider's billed charges on the waiver form is not a good faith estimate of the patient's responsibility.**

We realize that a provider will have to check in with the health plan first to get some of the information needed to calculate the patient's responsibility. We have advocated to the Texas Department of Insurance for a requirement that health plans furnish this data when requested without delay. The level of burden placed on a provider to produce an accurate projection of patient responsibility is acceptable given that the provider independently chooses whether to use the waiver form at all, and by using it, increases his/her options to collect reimbursements for services.

> **Recommendation:** Require one, clear price in the disclosure that tells a patient what s/he will owe to the out-of-network provider. Define in the rule that the price on the form must reflect what patient will owe the provider after taking into account: (1) the allowed amount determined by the plan and (2) what portion of the allowed amount, if any, is due from the patient to the provider. Clarify in rule that listing billed charge(s) is not sufficient. Eliminate any additional pricing or charge information from the disclosure form so that the patient gets clear and unambiguous information on their financial responsibility to the provider and can make an informed choice.

9. **The waiver forms as proposed in Figures 1 and 2 are difficult to read and understand and lack needed information. We urge you to edit them in a manner to prioritizes clear communication and understandability by a lay audience.**

Recommendations A – G below all relate to improving the wavier form(s).

Recommendation A: Ensure the form is understandable. This should be a top priority. It is critical that patients understand what they are agreeing to when they sign the waiver. It must be clear. The information should contain needed detail, but it needs to be presented in a straightforward, simple, and understandable way. It shouldn't contain legal language or jargon. It should be readable at the 8th grade level or lower. It is incumbent on TMB to get the technical assistance needed, if it does not exist in-house, to produce an understandable form. We would be happy to share an example of a clear disclosure form with you.

Recommendation B: Use an accurate, informative, and clear title. The form is not merely a notice or disclosure. It is designed to inform a choice the patient *must* make. An understandable form begins with a clear and accurate title. We recommend the following, or something similar:

Your price for health care from an out-of-network doctor
You must choose whether or not to accept this price

Recommendation C: Give patients all of the information they need to make an *informed* decision. Implications of the decision must be spelled out. There is a lot at stake in this form. A patient is being asked to waive the default prohibition on balance billing and agree to pay more. If the patient rejects the waiver, s/he may have to find an alternate provider and possibly delay needed care. If we want patients to make an informed choice the form must provide needed information and context. The form as proposed lacks critical information, without which a patient cannot make an informed choice.

- **The patient should be told both the amount they will have to pay the physician if they accept the waiver AND what they would pay under the default state law.** Nowhere in the proposed form does a patient learn that as a default, state law would limit the patient's payment to only the in-network copay, coinsurance, or deductible due under the health plan. **By signing this form, the patient may be agreeing to pay hundreds or thousands of dollars more than needed under state law.** The price trade-off is critical information for an informed decision.

- **The patient must know whether or not the physician will provide services if the patient rejects the waiver.** The price trade-off is just one dimension of the patient's decision. To be meaningfully informed, the patient must understand whether and how the election will affect their ability to get the needed health care from the specific out-of-network doctor.

- **The patient should know that if they accept the projected out-of-network price, that their health plan may not credit the amounts paid to their deductible or out-of-network maximum.** Patients are accustomed to their out-of-pocket payments accruing to their deductibles and out-of-pocket maximums. But health plans are likely to treat additional payments made under an SB 1264 waiver differently. Patients should be informed of this possibility and instructed to call their health plan to get more information.

- **The patient should be told what steps to take to get additional information during the "cooling off period."** The form should tell a patient that during the cooling off period, the patient can call their health plan and/or coordinating doctor to get information on alternate in-network options available at a lower cost**.**

Recommendation D: Put all needed information into one form; not two. Requiring a patient to cross reference forms adds needless complexity. We already recommended merging all information into one form because the statute requires that a patient be able to make a separate election for each out-of-network provider. The need for understandability also necessitates the use of just one form per provider. It is needlessly complex to ask a patient to cross reference multiple forms to make this decision. Patients should not have to attest on Figure 1 that they got a price written on Figure 2. The disclosed price (and all needed information) should be on the election form so there is no question about whether it was given by the provider and seen by the patient.

Many of the attestations on Figure 1 could be removed entirely and instead replaced directly with the needed information, including each of these:

- I, _____, (PATIENT/ENROLLEE NAME) HAVE BEEN INFORMED OF AND RECEIVED A COPY OF THIS NOTICE AND DISCLOSURE STATEMENT(S) CONCERNING THE BELOW-LISTED PROVIDER(S) OUT-OF-NETWORK STATUS.
- I have been provided the following:
    - 1. THE PROJECTED FINANCIAL RESPONSIBILITY FOR WHICH I MAY BE RESPONSIBLE FOR WHEN THE NONEMERGENCY HEALTH CARE SERVICES ARE RENDERED BY EACH OF THE ABOVE-REFERENCED OUT-OF-NETWORK PROVIDER.
    - 2. THE CIRCUMSTANCES UNDER WHICH I WOULD BE RESPONSIBLE FOR THOSE AMOUNTS DISCLOSED.
    - A SEPARATE NOTICE AND DISCLOSURE STATEMENT FROM EACH OUT-OF-NETWORK PROVIDER.
- 4. I acknowledge that I have received the following:
    - a. a COMPLETE list of all nonemergency health care services/procedures scheduled to be performed by each of the above-listed out-of-network provider.
    - b. A written disclosure of the projected total amount for the non-emergency health care services to be provided by each of the above-listed out-of-network provider(s), including any charges for health care or medical services and supplies.
    - c. A written statement containing the total amount to be billed amounts for each service provided by the out-of-network provider, less any insurance payments to the enrollee.

Recommendation E: Provide simple and clear projected pricing information, which shows what the patient will owe the provider, under the SB 1264 default and under a waiver. The distinctions between lines 2, 3, and 4 in proposed Figure 2 are not clear to us, but appear to give a patient pricing information that is unrelated to their financial responsibility, such as billed charges. Create instructions for the form, so the physician's office filling it out will understand what is included in and excluded from the price and can provide projections that are consistent and accurate.

The form should:

- Provide one projected, total price that will be owed if the patient accepts the waiver, and the price should be consistent with number 8 in our comments above;
- Provide one projected, total price that would be owed under the default in SB 1264, consisting of the patient's in-network copayment, coinsurance, and/or deductible; and
- Not provide any additional pricing or charge information.

Recommendation F: Attestations should focus on the consumer protections in the law/rule. As noted above, most of the attestations in Figure 1 can be replaced directly with the needed information. The attestations should focus on ensuring consumer protections, including asking patients to affirm:

- That they got the form *before* the procedure was scheduled with the treating doctor and facility.
- That they got the form at least ten business days prior to the potential procedure. **Note: as proposed the form say "7 days." This must be corrected to "10 business days."**
- That the provider reviewed the form with the patient in-person.
- That the patient got the "cooling off period," and was not asked to accept the waiver for 3 business days and got up to 5 business days to make the election.
- That the patient was not charged any non-refundable fees prior to communicating his/her election.

Recommendation G: The provider should attest to understanding the implications for the doctor if a patient accepts the election. Specifically, the provider should attest as part of the waiver form, that if the patient agrees to pay the disclosed balance bill that the provider foregoes: (1) payment from the health plan at the usual and customary rate, (2) prompt payment according to the timelines in SB 1264, and (3) the ability to use arbitration to seek additional payment from the health plan.

Thank you in advance for considering our comments. We especially urge you to address the three primary concerns we listed in the opening of our letter. We have provided specific recommendations and wording changes with the hope that it helps you accomplish this task. We believe that, with our recommended changes, these rules can provide strong protections for patients that are consistent with the language and intent of SB 1264. Should you have any questions about our comments, please contact Stacey Pogue at pogue@cppp.org and Blake Hutson at hutson@aarp.org.

Sincerely,

Stacey Pogue
Senior Policy Analyst
Center for Public Policy Priorities

Blake Hutson
Associate State Director
AARP Texas