Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

October 2, 2023

Re: HB 1592 & SB 2476 Rule Proposal Comments

Texas Department of Insurance,

As the statewide trade association representing health insurers, HMOs, Medicaid managed care, and other health plans that serve over 20 million Texans, the Texas Association of Health Plans (TAHP) is committed to ensuring that Texas families and employers have access to affordable, comprehensive, and high-quality coverage. This coverage includes safeguarding Texas patients from unexpected medical bills from out-of-network providers. Texas continues to lead the nation in patient protections with the passage of HB 1592, allowing ERISA plans to opt into state surprise billing protections, and SB 2476, which sets forth protections for patients against surprise billing from EMS providers. However, as these are new and untested policies, it's crucial for the agency to thoughtfully determine the most effective way to implement these new requirements. With this in mind, we offer the following suggestions.

First and foremost, we ask that these rules make it clear that an out-of-network EMS provider may not balance bill a patient. This agency currently has similar language in its rules related to the general balance billing prohibition, at 28 TAC 21.4903: "An out-of-network provider may not balance bill an enrollee receiving a nonemergency health care or medical service or supply, and the enrollee does not have financial responsibility for a balance bill…" Adding similar language to these rules would make it clear to providers and patients that balance billing for EMS services is prohibited.

Next, the negotiated intent of the bill was to allow local subdivisions the opportunity to submit rates annually. However, any rate increases would be capped at either the inflation index or 10%, whichever is lower. This was designed as a safeguard to protect consumers from rising insurance costs and artificially high rates. TAHP believes that regular automatic adjustments of required payments, without any cap, might lead to health plans paying providers more than the locally determined rates. This does not align with the bill's negotiated intent, and we ask that the agency correct the issue.

Alternatively, the agency could clarify in these rules that resubmissions are not allowed, and that the submitted rates will automatically increase each year. It is worth noting that SB 2476 does not contemplate resubmissions—it simply says that subdivisions may submit rates. While there

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should certainly be multiple opportunities for subdivisions to submit, it does not necessarily follow that a subdivision which has already submitted should be able to resubmit.

§21.5040. Required Explanation of Benefits and Enrollee Identification Card Information

Proposed subsections (b)(1) and (c) of this rule address the requirements for explanations of benefits (EOBs) and identification cards that have opted into state balance billing laws pursuant to HB 1592. As drafted, it is unclear whether these requirements also apply to EOBs and ID cards provided to non-residents. Even under the current overly broad interpretation of Article 21.42 and applicable extraterritoriality precedent, this agency would not have jurisdiction over services provided to non-residents. Practically speaking, the benchmarking database established by SB 1264 only extends to geozips in Texas, and therefore there would be no way for arbitrators to know the 80th percentile of billed charges in a geozip area outside of the state. Arbitrators making a determination without this information would therefore be violating Subdivision 1467.083(b)(6). Given that dispute resolution for out-of-state claims is effectively unworkable, we ask that the agency clarify in this rule that the EOB and ID card requirements for opted-in plans only apply to Texas residents. The current language in the rule will cause significant confusion for administrators and enrollees.

Additionally, the proposed language in subdivision (b)(2), which requires plans to include variable language in an EOB, would be very difficult to administer. The proposal requires issuers to include the health benefit plan name and the effective date of the election. This would require plans to regularly adjust their forms, and it is not clear what benefit the variable language provides. If a patient or provider receives an EOB from a plan that has opted in through Chapter 1275, they should receive a notice saying as much. However, the specific name of the plan and the effective date of the election will not provide any useful information to the provider, and it will require issuers to have a significant number of different EOB template forms, which will need to be updated regularly. We ask that the agency minimize unnecessary administrative burden by removing the variable language from the required notices.

Finally, at least one TAHP member plan has system limitations on the number of digits that can be added to self-funded ID cards. The health plan only has 3 digits available to identify eligibility for the state balance billing process. To avoid having to make expensive systemic changes, we ask TDI to consider allowing a 3-digit acronym, similar to “TDI.” For example,

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"IDR" could be used to assist providers and patients in identifying the appropriate mechanism to file a dispute.

§21.5060. Election Submission Requirements

This section, and specifically subdivision (a)(6), requires plan sponsors to provide the number of enrollees covered under a health benefit plan when they elect to participate in state balance billing laws. It would be helpful if the agency asked for an approximate number, the number of enrollees in employer-sponsored coverage can change regularly. Alternatively, the agency could ask for the number of enrollees on a certain date. This would help resolve potential questions from an administrator submitting an election.

§21.5070. Rate Database for Emergency Medical Services Providers

This proposal would allow political subdivisions to submit rates quarterly, which would be very difficult for plans to administer. Contracts are established, and plans are priced, on an annual basis. Adding out-of-network transport costs to plans is already going to create uncertainty—allowing those costs to change up to four times in a plan year will dramatically undermine any attempts to price this new coverage. These rate submissions should be aligned with the statutory Medicare inflation adjustments in the bill and existing insurer operating procedures, which would mean allowing updates annually. We have discussed this with other stakeholders, and we believe they will be submitting comments saying that annual submissions are acceptable to them as well.

The intent behind the bill was not to collect as much local rate data as possible. The goal of the legislature was to protect patients from surprise bills, as well as establish a payment standard for out-of-network transports. This is why, when subdivisions do not submit their own rates, the bill requires payment at either the billed charge or a percentage of Medicare. Allowing subdivisions the opportunity to submit rates was merely a way to ensure localities still have some control over what their constituents pay for services. Thus, while the submission portal and the data collection is a useful component of the legislation, the local rates are simply a means to an end, and should not be prioritized over functionality.

§21.5071. Payments to Emergency Medical Services Providers

Subsection (b)(1) of this section requires payment according to the submitted rate. Unfortunately, there are many zip codes in Texas that will fall into two or more political subdivisions. While providers may include specific pickup addresses on the standard claims form, they are not required to include anything more than the zip code. In other words, there could be situations

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where there are two submitted rates for a specific zip code, and there will not be enough additional information on a standard claim form for a plan to determine which submitted rate is appropriate.

There is no feasible way for plans to change claims structure and processes, as this is standardized nationally. Any programming change to address this would be at a significant cost to plans and implementation would take time. Plans are processing millions of claims a month. It is not possible to have a manual process for revising and checking these claims. Moreover, SB 2476 is a temporary solution as we wait for federal protections from ground ambulance balance bills, which is why the bill sunsets on September 1, 2025. Given that this is not a long-term solution, the rules should not require expensive long-term structural changes. Texas should not create an overly burdensome and expensive process that may not be feasible to address this issue.

While this zip code problem was not contemplated by the bill, SB 2476 includes language saying that the insurer is required to reimburse when a claim is submitted "that includes all information necessary for the insurer to pay the claim." If a zip code could fall into two or more political subdivisions, and the provider fails to include the specific originating address, then the issuer does not have all the information necessary to pay the claim. To address these cases, we ask that the agency include language in this rule saying that the issuer may pay either rate. The agency could then require that issuers have an internal appeal process for providers to resolve claims that providers feel were paid incorrectly.

Another issue in this section is within Subsection (c). At subdivisions (1), (2), (3), and (4), the rules refer to "claims submitted" before or after certain dates. Likewise, in the Examples provided in the section, "claims submitted" and "claims incurred" appear to be used interchangeably. We ask that throughout this rule, the agency clarify that the relevant date is the date the service was provided—not when the claim was submitted. In other words, if a service is provided in one submission period, but the claim is submitted months later in a separate submission period, the applicable rate is the period in which the service was provided. SB 2476 is clear: a plan is to "pay for a covered health care or medical service performed for… an enrollee…at" the statutory rate.

It is critical that the payment be tied to the performance of the service—not the date the bill is submitted. If the payment is tied to the submission date of a claim, there will be an incentive for providers to take advantage of the system by holding onto claims in anticipation of a higher rate. These unnecessary delays would create uncertainty for plans, as providers could hold onto a

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significant number of claims as the effective date of new rates approaches. In turn, this may result in higher out-of-pocket costs for patients, based on the applicable cost-sharing requirements.

Thank you for this opportunity to comment on these important rules. While we expect that it will take some time to adjust to the new laws, we appreciate that the agency has asked for industry feedback on implementation. Please contact us if you have any questions.

Sincerely,

Jamie Dudensing, RN
CEO
Texas Association of Health Plans