

Senate Bill 1264: The Texan Template for the National Fight Against Balance Billing

Alexander Haer*

Balance billing occurs when out-of-network health care providers send bills to otherwise-insured patients because the providers do not have a contractual obligation to charge a certain rate with the patient's health plan. This usually occurs in emergency situations, or where the patient cannot consent to treatment. This can lead to massive surprise medical bills of up to hundreds of thousands of dollars, which the health plan is often unwilling to pay. Balance billing has become a national issue, and many states are formulating legislative solutions to fix the problem. In Texas, Senate Bill 1264 (SB 1264) was passed in 2019 with a wide bipartisan majority. SB 1264 is designed to completely reform how Texas and her state agencies deal with surprise medical bills and insulate patients from liability.

This Note will take a close look at the problem of balance billing and explore the Texas regulations that were in effect prior to SB 1264. It will then closely analyze the most important reforms implemented by SB 1264 and the administrative rules passed to govern the bill's execution. This will include a look at the political controversy that threatened to destroy the bill before it was fully implemented. Finally, this Note will evaluate SB 1264 by providing a critical appraisal of its central provisions. This appraisal will include how the new regulations could save costs for COVID-19 patients and will make recommendations for improving the law's effectiveness.

This Note analyzes the scholarship surrounding Texas's most expansive attempt to protect patients from surprise medical bills, critically evaluates the many facets of the reform, and synthesizes these elements to conclude that SB 1264 should be cautiously used as a national standard for leading the fight against balance billing.

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* Associate Editor, Volume 99, *Texas Law Review*; J.D. Candidate, Class of 2021, The University of Texas School of Law.

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Introduction

When Americans are asked which bills they are the most worried about being able to afford, the category that invokes the most consternation is often unexpected medical bills.¹ Sixty-seven percent of Americans describe themselves as either very worried or somewhat worried about their ability to pay these obligations, which can be accrued without the informed consent, or even awareness, of the patients themselves.² An article published in 2014 by the *New York Times* effectively articulates why surprise medical bills are so feared: large and unexpected medical bills can happen to anyone, even those who thought they were fully insured.³

The practice of leveling unexpected medical bills at those with health insurance is referred to as balance billing, and increasing public concern has made this issue a central target for legislative reforms at both the state and national levels.⁴ These reforms have not proceeded uniformly, with state governments and the national government each pushing for a myriad of legislative solutions.⁵ Texas joined the fray last year with Senate Bill 1264 (SB 1264), a bipartisan legislative solution designed to insulate health care

1. Karen Pollitz, Matthew Rae, Gary Claxton, Cynthia Cox & Larry Levitt, *An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them*, PETERSON-KFF: HEALTH SYS. TRACKER (Feb. 10, 2020), <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/> [<https://perma.cc/QR2Q-GYHG>].

2. *Id.*

3. See Elisabeth Rosenthal, *After Surgery, Surprise \$117,000 Medical Bill from Doctor He Didn't Know*, N.Y. TIMES (Sept. 20, 2014), <https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html> [<https://perma.cc/T84W-PH28>] (chronicling the experiences of several patients, many of whom performed their due diligence and were still hit with a large medical bill).

4. Pollitz et al., *supra* note 1.

5. *Id.*

consumers from balance billing.⁶ This bill represents a majorly significant effort by the country's second-most-populous state to set a national standard for other states to follow when implementing their own balance billing reforms.⁷

This Note will proceed in three parts. Part I will define balance billing and identify the situations where balance billing is most likely to occur, look at the Texas regulatory landscape as it existed prior to the passage of SB 1264, and elaborate on why the issue has become an increasingly important part of health care reform efforts in the past few years. Part II will closely analyze SB 1264 and outline the significance of the central tenets of the legislation. This Part will also inspect the rules that Texas state agencies, such as the Texas Department of Insurance (TDI), have formulated for the interpretation of SB 1264. This inspection will include a look at the controversy originating from rules proposed by the Texas Medical Board (TMB), which culminated in a publicly issued threat by Lieutenant Governor Dan Patrick to not reappoint the TMB board members who approved what he considered to be a problematic rule interpreting the legislation.⁸ Part III will incorporate the previous analyses and evaluate the efficacy of SB 1264 and the rules governing its application. The evaluation will include criticisms, predictions, and recommendations. It will also look at the role that SB 1264 could play in mitigating potential financial costs to the victims of the COVID-19 pandemic. It will conclude with a recommendation that SB 1264 and the rules promulgated to interpret it be used as a template for other state efforts fighting against balance billing.

I. Balance Billing and the Texas Regulatory Landscape Prior to SB 1264

A. *Balance Billing Defined*

The practice of balance billing refers to an out-of-network health care provider's ability to bill a patient directly for the difference between what the patient's health plan paid for a service (if anything) and what the provider

6. Ashley Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, NPR (June 18, 2019) [hereinafter Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*], <https://www.npr.org/sections/health-shots/2019/06/18/733369370/texas-is-latest-state-to-attack-surprise-medical-bills> [<https://perma.cc/EYU7-PV56>].

7. *Texas Population 2020 (Demographics, Maps, Graphs)*, WORLD POPULATION REV., <https://worldpopulationreview.com/states/texas-population> [<https://perma.cc/2AKX-XDSA>]; see Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, *supra* note 6 (describing the bill as one of the strongest balance billing state protections yet and suggesting that Texas state action will spur federal lawmakers).

8. Julie Chang, *Lt. Gov. Patrick Threatens Medical Board over Surprise Billing Rule*, AUSTIN AM. STATESMAN (Nov. 27, 2019, 3:13 PM), <https://www.statesman.com/news/20191127/lt-gov-patrick-threatens-medical-board-over-surprise-billing-rule> [<https://perma.cc/689T-6TML>].

charges for the service.⁹ Balance billing occurs because, while an in-network provider has negotiated a payment rate with an individual's health plan, an out-of-network provider does not have a contractual obligation to charge a certain rate.¹⁰ As a result, the out-of-network provider can charge a fee far higher than what the health plan considers to be fair and reasonable.¹¹ The patient will then be billed for the difference between what the health plan paid and what the provider charged.¹² The difference between what the health plan is willing to pay and what the provider charges can reach large amounts—into the hundreds of thousands of dollars.¹³ When this occurs voluntarily, and a patient is willing to pay more for an out-of-network provider, balance billing should not provoke much consternation. However, the reason balance billing practices often result in surprise medical bills is because patients are often unaware that they have been treated by an out-of-network provider or are in a situation where they are unable to select an in-network provider instead.¹⁴ Balance billing happens most often in circumstances where the patient has little to no control over whether they are seeing an in-network provider.¹⁵

By far the most common involuntary contact with out-of-network health providers comes from emergency care, accounting for a full 68% of involuntary contact cases in 2011.¹⁶ This is an area of special vulnerability, and in some cases, patients might not even be coherent enough to consent to see a physician at all. This problem is compounded by the reality that many emergency physicians working at in-network hospitals are out-of-network themselves; a recent study conducted by the Every Texan, formerly known as Center for Public Policy Priorities, drew heavily on information released by the TDI and found that more than 20% of Texas hospitals covered by one of Texas's largest health insurers, Blue Cross Blue Shield, had "no in-network emergency physicians."¹⁷ However, even this pales in comparison to the 56% of Humana's (one of Texas's three largest insurers) in-network

9. Brooke Murphy, *20 Things to Know About Balance Billing*, BECKER'S HOSP. CFO REP. (Feb. 17, 2016), <https://www.beckershospitalreview.com/finance/20-things-to-know-about-balance-billing.html> [<https://perma.cc/7V9U-BCNR>].

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. STACEY POGUE & MEGAN RANDALL, CTR. FOR PUB. POL'Y PRIORITIES, SURPRISE MEDICAL BILLS TAKE ADVANTAGE OF TEXANS: LITTLE-KNOWN PRACTICE CREATES A "SECOND EMERGENCY" FOR ER PATIENTS 3-4 (2014), https://www.academyhealth.org/files/HC_2014_09_PP_BalanceBilling.pdf [<https://perma.cc/DP2K-L7FH>].

hospitals that have no in-network emergency room physicians.¹⁸ Indeed, the largest three insurers in Texas (United Healthcare, Blue Cross Blue Shield, and Humana) report that an incredible 41% to 68% of billings for emergency professional services at network hospitals were by nonparticipating physicians.¹⁹

Balance billing also commonly results from hospitals utilizing physician outsourcing firms to secure specialists or outside surgeons.²⁰ These specialists are less likely to be in-network and are often called in to work on a patient's case without the patient's knowledge.²¹ The aforementioned *New York Times* article cites an example of this practice: one patient, after a herniated disc surgery, was sent charges by more than ten health care providers, many of whom he could not even remember.²² The statistics for these specialist groups of physicians were better than those for emergency care physicians, but still sobering.²³ About a third of Humana's network hospitals did not have in-network radiologists or anesthesiologists participating, and a fifth did not have neonatologists or pathologists.²⁴ For both Humana and United, almost a quarter of billings for anesthesiologists in in-network hospitals were by out-of-network physicians.²⁵

The effects of balance billing can be especially painful for patients trying to access certain niche services.²⁶ Americans living in rural areas are often forced to rely on air ambulances for transfer to facilities with the equipment and expertise to treat serious medical problems.²⁷ These flights can be very expensive, and there is often not an available in-network air ambulance provider nearby.²⁸ These lifesaving services can often end up costing the patient tens of thousands of dollars, despite there being no in-network recourse available.²⁹

In summary, surprise medical bills frequently occur in emergency situations and when specialists are required.³⁰ These charges are fairly common and can be very difficult to avoid.³¹ A 2015 study from the

18. *Id.* at 3 tbl.1.

19. *Id.*

20. Murphy, *supra* note 9.

21. *See, e.g.*, Rosenthal, *supra* note 3 (chronicling the story of patients who were sent bills from surgeons they had never met).

22. *Id.*

23. POGUE & RANDALL, *supra* note 17, at 5 fig.2.

24. *Id.* at 6 fig.3.

25. *Id.* at 5 fig.2.

26. Murphy, *supra* note 9.

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

Consumer Reports National Research Center illustrates the scope of the problem.³² The study found that 87% of Americans did not know which state government department handled health care complaints, nearly a third of Americans with private insurance received an unexpected medical bill in the past two years, and 57% of that group ended up paying that bill personally.³³

Balance billing has been increasingly recognized as a complex and difficult problem for health care consumers, and at least twenty-five states so far have developed legislation designed to mitigate the financial harm.³⁴ However, it must be noted that any state regulations passed to address balanced billing will inherently be limited in application. This is because many health plans cannot be regulated by the states.³⁵ The Employee Retirement Income Security Act of 1974 (ERISA) is a complex act that regulates private industry health plans.³⁶ Specifically, ERISA regulates many health plans that are obtained directly by employers for their employees.³⁷ This system of regulations invokes the federal preemption doctrine and prevents state regulation of plans that ERISA already regulates.³⁸ In Texas, the federal government regulates about 40% of plans,³⁹ these plans were not affected by Texas's past regulatory framework and will likewise not be directly affected by SB 1264.

B. *Texas's Old Framework*

Texas's regulatory process for dealing with balance billing prior to January 1, 2020, the date that SB 1264 became effective, was largely

32. Chuck Bell, *Consumer Reports Survey Finds Nearly One Third of Privately Insured Americans Hit with Surprise Medical Bills*, CONSUMER REP. (May 7, 2015), https://advocacy.consumerreports.org/press_release/consumer-reports-survey-finds-nearly-one-third-of-privately-insured-americans-hit-with-surprise-medical-bills/ [<https://perma.cc/YE5W-GE8X>].

33. *Id.*

34. Michael Ollove, *Surprise Medical Billing: Some States Ahead of Feds*, PEW CHARITABLE TRUST: STATELINE (Apr. 5, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/04/05/surprise-medical-billing-some-states-ahead-of-feds> [<https://perma.cc/E3N5-DNW2>].

35. See Editorial Board, *Texans off the Hook for 'Surprise' Medical Bills*, HOUS. CHRON. (Aug. 6, 2019) [hereinafter Chronicle Editorial Board], <https://www.houstonchronicle.com/opinion/editorials/article/Texans-off-the-hook-for-surprise-medical-14282165.php> [<https://perma.cc/4X8R-K824>] (describing a Texas health-plan law's lack of reach because federal law regulates some of the market already).

36. *Id.*

37. *Id.*

38. Abbe R. Gluck, Allison K. Hoffman & Peter D. Jacobson, *ERISA: A Bipartisan Problem for the ACA and the AHCA*, HEALTH AFR. (June 2, 2017), www.healthaffairs.org/doi/10.1377/hblog20170602.060391/full/ [<https://perma.cc/ZDL3-6TGE>].

39. Chronicle Editorial Board, *supra* note 35.

finalized in 2017.⁴⁰ As a first line of defense, patients were advised to try to work out the issue with their health plan.⁴¹ If this discussion was unsuccessful, the patient could make a formal request for mediation by filling out a mediation request form.⁴² Mediation could only be requested under certain circumstances: the bill must have been more than \$500, and the patient must have received care from an out-of-network provider for services rendered in an in-network hospital.⁴³ Lastly, the patient's health plan must have been regulated by the state and could not have been regulated by ERISA.⁴⁴

Once the mediation request was made and the provider was notified, the provider was not allowed to attempt to collect payment while the mediation process continued.⁴⁵ Within thirty days of the formal mediation request, the health insurance company and the health care provider were required to have an informal conference by telephone.⁴⁶ If this informal conference failed, the mediation would be held within 180 days of the formal mediation request.⁴⁷ The mediator would either be appointed by the State Office of Administrative Hearings (SOAH) or would be unanimously selected by all parties to the mediation.⁴⁸ The mediator's fees would be split evenly between the health care provider and the insurance company.⁴⁹ The patient did not have to attend the mediation but could if he or she wished; he or she could also have attended the mediation with a representative or could have sent a representative instead of attending.⁵⁰ The patient was guaranteed a chance to make their case, and the mediation was generally capped at four hours.⁵¹ If no agreement was reached by the parties, the issue could be referred to a judge.⁵²

The TDI stated that “the goal of the mediation is to reach an agreement between you, your provider, and the company as to the amount charged by

40. Jay Root & Shannon Najmabadi, *Thousands of Texans Were Shocked by Surprise Medical Bills*, TEX. TRIB. (Feb. 12, 2019), <https://www.texastribune.org/2019/02/12/texas-mediation-balance-billing-faces-massive-backlog/> [<https://perma.cc/F582-VPF7>].

41. CTR. FOR PUB. POL'Y PRIORITIES, OH NO! I GOT A SURPRISE MEDICAL BILL. NOW WHAT? 2 https://everytexasan.org/images/HW_2018_SurpriseMedicalBill_WhatToDo.pdf [<https://perma.cc/RHP6-PZQP>].

42. *Id.* at 3.

43. *Id.*

44. *Id.* at 4.

45. *How Mediation Works*, TEX. DEP'T OF INS., <https://www.tdi.texas.gov/consumer/cpmmediation3.html> [<https://perma.cc/8HS3-ZENU>].

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

the provider, the amount paid by the company to the provider, and the amount paid by you to the provider.”⁵³ However, the TDI also made it clear that the patient can end up paying under the mediation system,⁵⁴ especially if the issue is referred to court (which would be a costly proposition for one already potentially burdened with expensive surprise medical bills). It is clear that this system is designed primarily to encourage informal resolution of balance billing and impose basic transaction costs such as the cost of the mediator, the cost of travel, and lost employee hours on health care providers and insurers in an effort to get them to negotiate a deal early in the process. While informal and voluntary resolution systems certainly lack the security and heightened protection that more comprehensive reform provides, there is evidence that this system worked fairly well—when it worked as it was supposed to.⁵⁵

The TDI announced that, during the 2018 fiscal year, \$9.7 million of surprise medical bills were contested through the mediation process.⁵⁶ The department stated that, as a result of the informal telephone conference alone, those charges were reduced down to just \$1.3 million in total.⁵⁷ In fact, informal telephone conference resolves most cases; only about one-tenth of all cases (roughly 1,100) have been sent to SOAH since 2013.⁵⁸ While these numbers would seem to indicate that the mediation process was working well, there were good reasons to be skeptical.⁵⁹ There are doubts that the program was well-known enough to be truly effective, despite increasing public awareness of balance billing.⁶⁰ And some patients simply ended up paying the bill out of fear that the mediation process would require them to hire a lawyer to contest the charges.⁶¹ However, there is evidence that awareness of the mediation program was rising in the years leading up to the passage of SB 1264.⁶² This increase in interest led to problems of its own as rising numbers of Texans began requesting TDI’s assistance in resisting payment of their surprise medical bills.⁶³

53. *Id.*

54. *Id.*

55. Ashley Lopez, *Faced with Surprise Medical Bills, Some Texans Have Recourse. But the System’s Not Perfect*, KUT (Jan. 17, 2019) [hereinafter Lopez, *Faced with Surprise Medical Bills, Some Texans Have Recourse*], <https://www.kut.org/post/faced-surprise-medical-bills-some-texans-have-recourse-systems-not-perfect> [<https://perma.cc/2Q9V-B8DV>].

56. *Id.*

57. *Id.*

58. Root & Najmabadi, *supra* note 40.

59. See Lopez, *Faced with Surprise Medical Bills, Some Texans Have Recourse*, *supra* note 55 (describing the issues with the mediation process).

60. *Id.*

61. *Id.*

62. Root & Najmabadi, *supra* note 40.

63. *Id.*

The TDI mediation process began to develop an increasingly large backlog of thousands of Texans requesting the agency's help.⁶⁴ State regulators believe that recent news stories raised awareness of the program and caused demand to rapidly increase.⁶⁵ The TDI received just 43 mediation requests in 2013; in 2018 they received 4,519.⁶⁶ The backlog of Texans requesting assistance had reached nearly 4,000 requests by the fall of 2018, and the TDI expected to receive 8,000 requests in 2019.⁶⁷ In 2018, there were only two staffers tasked with handling the mediation requests.⁶⁸ The TDI hired eight more staffers that year, but progress toward clearing the backlog remained slow and difficult.⁶⁹ In the TDI spokesperson's own words, the process was "kind of like the snake eating the mouse."⁷⁰

It should be noted that, even when it did run to completion, the success of the mediation program was difficult to evaluate because the TDI did not track one very important variable in particular—how much the consumer ended up paying of the final negotiated amount.⁷¹ As a result, it is hard to tell exactly how well the program has reduced the burden of balance billing on the patients themselves. It is most accurate to characterize the formal mediation process as a good faith attempt to lighten the burden that balance billing imposes on Texas health service consumers. That said, the demand for TDI assistance appears to have overwhelmed the agency's ability to effectively manage the program, and the program suffers from underpublicization and an overreliance on resolution procedures that can potentially leave consumers with a substantial part of the bill through no fault of their own.⁷² Texas's new push to regulate balance billing, SB 1264, aims to radically transform the process and relieve consumers of liability.⁷³

II. A Review of SB 1264: The Central Provisions and the Controversy

A. *Central Provisions*

The Texas Legislature's creation of a mediation-centered regulatory system in 2017 to address balance billing was a good-faith attempt to

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* (quoting TDI Spokesperson Stephanie Goodman).

71. *Id.*

72. *See id.* (describing problems with the mediation process in the old program); Lopez, *Faced with Surprise Medical Bills, Some Texans Have Recourse*, *supra* note 55 (describing the lack of public awareness for the program).

73. Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, *supra* note 6.

provide much needed assistance on an issue that was becoming increasingly important to Texan health care consumers, and the program achieved some limited successes.⁷⁴ However, SB 1264 constitutes by far the legislature's largest and most comprehensive attempt to reform how balance billing is treated in Texas.⁷⁵ It aims to restrict balance billing by targeting some of the instances when surprise medical bills are most likely: out-of-network providers providing emergency medical services, out-of-network providers working at an in-network facility, and out-of-network diagnostic and laboratory services that were performed in tandem with health care provided by an in-network physician.⁷⁶ It must again be noted that SB 1264 is state legislation and does not affect ERISA-regulated plans.⁷⁷ SB 1264 primarily applies to state-regulated health plans, such as the Teacher Retirement System, the Texas Employees Group Benefits plan, and the TRS-ActiveCare program.⁷⁸

One of the larger changes from the old system to the new one is that SB 1264 aims to remove the consumer from the dispute.⁷⁹ SB 1264's statement of intent articulates that "[t]he bill prohibits all non-network . . . providers from sending surprise balance bills to consumers."⁸⁰ The consumers will now be responsible only for "their applicable co-pay, coinsurance, and deductible amounts."⁸¹ This means that rather than being able to send the balance of the bill directly to consumers, as they were able to previously, providers will now have to deal directly with the health plan.⁸² When an out-of-network provider bills a consumer for a service, the health plan must submit a "Balance Bill Prohibition Notice" to both the physician and consumer that, among other requirements, (1) contains notice of the prohibition against balance billing, (2) informs the health care provider of the amount they are allowed to charge the consumer under the health plan, and (3) explains the availability of mediation and arbitration to the health care

74. See Lopez, *Faced with Surprise Medical Bills, Some Texans Have Recourse*, *supra* note 55 (describing the improved awareness and use of the mediation process in the old program).

75. Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, *supra* note 6.

76. See MARK A. HALL, PAUL GINSBURG, STEVEN M. LIEBERMAN, LOREN ADLER, CAITLIN BRANDT & MARGARET DARLING, *THE SCHAEFFER INITIATIVE FOR INNOVATION IN HEALTH POL'Y, SOLVING SURPRISE MEDICAL BILLS 5-6* (2016), <https://healthpolicy.usc.edu/research/solvingsurprisemedicalbills/> [<https://perma.cc/X7NE-8CDM>] (noting common problems in balance billing).

77. S. Comm. on Bus. & Commerce, Bill Analysis, *Tex. S.B. 1264*, 86th Leg., R.S. (2019), <https://capitol.texas.gov/tlodocs/86R/analysis/pdf/SB01264I.pdf> [<https://perma.cc/JX7J-ABT5>].

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.*

provider.⁸³ Then, within thirty days of receiving an electronic claim from the provider, the health care plan must pay the out-of-network provider the “usual and customary rate,” or the agreed rate that the health plan has established for providers at the in-network facility where the service was performed.⁸⁴

If the provider is dissatisfied with the payment, he or she can contest the bill and request either mandatory mediation (if it is an out-of-network facility like a hospital) or mandatory binding arbitration (if the provider is a non-facility out-of-network provider).⁸⁵ In either case, at least one aspect of the former regulatory framework has survived: the provider and insurer must have an informal teleconference within thirty days of the complaint.⁸⁶ Both the mediation and arbitration systems, which were not available in the former regulatory framework, are run by the TDI.⁸⁷ Both types of contests can be requested through an online website portal run by the TDI termed the Independent Dispute Resolution Portal.⁸⁸ This request marks the beginning of a thirty-day informal settlement period, where the parties can either settle or agree on a mediator or arbitrator for the dispute.⁸⁹ If the parties cannot agree within this period, TDI will assign a mediator or arbitrator.⁹⁰ If the parties wish for the mediator’s or arbitrator’s findings to be reviewed, either party can file an action in civil court within forty-five days after the final decision of the arbitrator or forty-five days after the mediator’s report is filed in the TDI’s Independent Dispute Resolution Portal.⁹¹

If the parties’ dispute is subject to mediation, the mediator will evaluate whether the amount charged by the out-of-network provider is “excessive,” and whether the health plan’s payment is “usual and customary” or “unreasonably low.”⁹² The goal of the mediation will be for the insurer and

83. Act of Sept. 1, 2019, 86th Leg., R.S., S.B. 1264, § 1.02 (codified at Tex. Ins. Code § 1271.008).

84. *Id.* § 1.04 (codified at Tex. Ins. Code § 1271.157).

85. Theresa Langley, *SB 1264 Restricts Certain Providers from Balance Billing in Texas*, HUSCHBLACKWELL: HEALTHCARE L. INSIGHTS (July 15, 2019), <https://www.healthcarelawinsights.com/2019/07/sb-1264-restricts-certain-providers-from-balance-billing-in-texas/> [<https://perma.cc/T8D5-MXVF>].

86. *Id.*

87. *Id.*

88. *FAQ: Mediation and Arbitration Requirements and Processes*, TEX. DEP’T OF INS. [hereinafter TEX. DEP’T OF INS., *FAQ: Mediation and Arbitration Requirements and Processes*], <https://tdi.texas.gov/medical-billing/idr-process-faqs.html> [<https://perma.cc/92GP-9CEX>].

89. *Id.*

90. *Id.*

91. *Id.*

92. Act of Sept. 1, 2019, 86th Leg., R.S., S.B. 1264, § 2.12 (codified as an amendment to Tex. Ins. Code § 1467.056(a)).

the provider to come to an agreement as to what constitutes a fair billing; the consumer will not need to be involved.⁹³

The mandatory arbitration included in SB 1264 adds an entirely new dynamic to the regulatory structure for controlling balance billing. The process has been described as “baseball-style arbitration” because (similar to Major League Baseball’s arbitration system) the arbitrator is tasked with determining whether the charge billed by the provider or the payment made by the health plan is the closest to the “reasonable amount for . . . the services or supplies.”⁹⁴ The arbitrator must pick one side or the other and cannot modify the amount of the award.⁹⁵ It should be noted that both the provider and health plan can modify the amount that they offer throughout the resolution process, so that the initial amounts they billed or charged might not be the amounts that the arbitrator actually chooses between.⁹⁶ The arbitrator must make the determination based on ten different factors.⁹⁷ Some of the most relevant factors that must be considered include: (1) the education and experience of the provider; (2) what the provider usually bills for comparable services; (3) the circumstances of each individual case; (4) the eightieth percentile of all charges billed for comparable services in the same geographic area; and (5) the fiftieth percentile of rates paid to providers for similar services in the same geographic area.⁹⁸

SB 1264 also has more teeth than the previous system: regulatory agencies, like the TMB, TDI, and the Texas Department of Licensing and Regulation, can discipline providers and insurers for failing to comply with the bill’s provisions.⁹⁹ Additionally, upon referral from the interested state agency, the Texas Attorney General can seek an injunction against health plans and providers that routinely, and intentionally, violate the law through “billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible.”¹⁰⁰

93. *See id.* (codified as an amendment to Tex. Ins. Code § 1467.056(d)) (indicating that the only parties required for the mediation are the issuer and out-of-network provider).

94. *Id.* § 2.15 (codified at Tex. Ins. Code § 1467.083); *see* Rachel Bluth, *To End Surprise Medical Bills, New York Tried Arbitration. Health Care Costs Went Up*, NPR (Nov. 5, 2019, 12:21 PM), <https://www.npr.org/sections/health-shots/2019/11/05/776185873/to-end-surprise-medical-bills-new-york-tried-arbitration-health-care-costs-went-up> [<https://perma.cc/Q28Z-XRR2>] (describing baseball-style arbitration).

95. Act of Sept. 1, 2019, 86th Leg., R.S., S.B. 1264, § 2.15 (codified as an amendment to Tex. Ins. Code § 1467.083).

96. *Id.*

97. *Id.* (codified at Tex. Ins. Code § 1467.083).

98. *Id.*

99. *See id.* § 1.01 (codified at Tex. Ins. Code § 752.0003) (permitting regulatory agencies that license, certify, or authorize health care practice or operations in the state to take disciplinary action).

100. *Id.* (codified at Tex. Ins. Code § 752.0002).

SB 1264 represents a substantial reform of Texas's current regulatory system for managing balance billing.¹⁰¹ The new legislation has been described as “strong or stronger than any of the protections in the country.”¹⁰² Indeed, the bill represents an overhaul of the entire process.

The most important changes appear to be that consumers should now never directly be charged the balance of the bill and non-facility out-of-network providers will have to go through mandatory “baseball-style arbitration” in order to contest the initial billing sent to them by the health plan.¹⁰³ The mediation process for out-of-network facilities appears to be slightly reoriented so that the customary rate is more important to the resolution amount.¹⁰⁴ The only significant holdovers appear to be the informal teleconference and that the TDI is still charged with running the programs. To summarize, SB 1264 seems to be an ambitious and comprehensive legislative attempt at reforming how Texas deals with balance billing. Taken together, the bill's innovations would protect consumers from surprise medical bills, which they likely accrued through no fault of their own. However, the reform has been controversial, and there are several potential issues that could impede the full realization of SB 1264's stated intent to prevent Texans from receiving surprise medical bills.¹⁰⁵

B. Controversy

SB 1264 represents an ambitious attempt to create a comprehensive regulatory system for controlling balance billing. However, it has endured some recent controversy.¹⁰⁶ The controversy centered over new agency rules proposed by the TMB, which consumer advocates believed would turn what is meant to be a narrow exception into a loophole in the bill.¹⁰⁷ SB 1264 creates an exception for health care consumers who would like to be treated by a health care provider outside of their network and are aware that they will be paying a premium for the service.¹⁰⁸

Specifically, SB 1264's protections do not apply if the medical service is nonemergency, and if the patient receives and signs written notice explaining: (1) the provider and the health plan do not have a contract, (2) the patient's expected financial responsibility, and (3) the circumstances where

101. Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, *supra* note 6.

102. *Id.*

103. Act of Sept. 1, 2019, 86th Leg., R.S., S.B. 1264, § 2.15 (codified at Tex. Ins. Code § 1467.084).

104. *See id.* § 1.04 (codified at Tex. Ins. Code § 1271.157) (requiring payment for out-of-network services to be at the “usual and customary rate” for such services).

105. Chang, *supra* note 8.

106. *Id.*

107. *Id.*

108. *Id.*

the financial responsibility would belong to the patient.¹⁰⁹ However, many observers argued that the administrative rules created by TMB expanded this loophole far beyond the spirit of the foundational legislation.¹¹⁰ The rule stated that “an out-of-network provider shall provide written notice and disclosure to an enrollee prior to providing nonemergency health care or medical services to the enrollee.”¹¹¹ John Ford, the spokesman for the Texas Association of Health Plans, said that the proposed rule “encourages providers and at worst, it actually requires providers to give a form to patients—this is for non-emergency care—that if signed would waive the surprise billing protection that (SB) 1264 gave them.”¹¹² If the patient did not sign the waiver, the physician would be able to decide whether or not to continue with the procedure.¹¹³ Ford was not the only person displeased with the new rules: Lieutenant Governor Dan Patrick released a statement saying that “[a]fter passing the strongest ‘surprise billing’ protections in the nation, I am not happy to learn that attempts may be being made at the Texas Medical Board to create a loophole to undermine this important law.”¹¹⁴ He went on to imply that members of the TMB could find themselves without a job if they support the rule, stating that “it is unlikely the votes would be there to . . . approve the reappointment of any member who votes to circumvent the intent of clearly written legislation.”¹¹⁵

In the face of mounting criticism the TMB relented; they withdrew the rule and passed authority to formulate a rule governing the exception over to the TDI, which has broader jurisdiction over medical providers.¹¹⁶ The TDI adopted rules governing the exception on an emergency basis on December 20th.¹¹⁷ The new rule is much different from the one proposed by the TMB and makes it clear that a patient can only waive SB 1264’s balance billing protections when: (1) it is not an emergency, (2) the patient “has a meaningful choice between a participating provider . . . and an out-of-network provider,” (3) the patient is not coerced into the choice, and (4) written notice is provided and signed by the patient at least ten business

109. Langley, *supra* note 85.

110. Chang, *supra* note 8.

111. Out-of-Network Provider Notice and Disclosure Requirements, 44 Tex. Reg. 6667 (Nov. 8, 2019) (proposed but ultimately withdrawn).

112. Chang, *supra* note 8.

113. *Id.*

114. *Id.*

115. *Id.*

116. *Texas Medical Board Axes Proposal that Undermined New ‘Surprise Billing’ Law*, DALL. MORNING NEWS (Dec. 6, 2019, 10:43 AM), <https://www.dallasnews.com/business/health-care/2019/12/06/texas-medical-board-axes-proposal-that-undermined-new-surprise-billing-law/> [<https://perma.cc/ZX3X-LRCH>].

117. 28 TEX. ADMIN. CODE § 21.4903 (2019).

days before the procedure.¹¹⁸ Meaningful choice is not considered to be present if an out-of-network provider is assigned to the case by another provider or administrator.¹¹⁹ Coercion occurs when a provider attempts to charge a nonrefundable fee prior to the waiver.¹²⁰ Additionally, the TDI specified that the waiver “must be presented to an enrollee as a stand-alone document and not incorporated into any other document.”¹²¹ These rules provide an arsenal of protections lacking in the initial TMB formulation, and their announcement was met with relief from patient advocates.¹²² However, SB 1264 must still overcome a number of challenges in order to become the powerful consumer-protection bill that its sponsors intended it to be.

III. Evaluation of SB 1264

SB 1264 represents a sea change for how balance billing will be treated in Texas. However, as illustrated by the early controversy that the bill has faced, such an encompassing and financially impactful piece of legislation will face many obstacles to realizing its objective of fully protecting consumers from balance billing. Some of the criticisms and challenges to be addressed when considering the efficacy of the bill include: the scope of the legislation, the concerns of some health care providers, the administrative capabilities of the agencies tasked with upholding the reforms, and the effectiveness of the TDI emergency rules governing SB 1264’s controversial waiver of protections.

The case for using SB 1264 as a national template for reforms protecting against balance billing is supported by the case data from other reform-minded states and by the reports of public policy institutions. A final important consideration when evaluating SB 1264 as a national template and as an effective reform for Texans is the role the new laws could play in mitigating the costs of the COVID-19 pandemic for health care consumers.

A. Criticisms and Challenges

1. Scope of the Legislation.—The largest problem that SB 1264 faces, in terms of its ability to reform balance billing for all Texans, is the limited universe of health plans that fall within the bill’s purview. As mentioned earlier, the bill applies only to some non-ERISA health plans run by the state

118. *Id.*

119. *Id.*

120. *Id.*

121. *Id.*

122. Taylor Goldenstein, *Loophole Closed in Texas Law Designed to Protect Against Surprise Medical Billing Law*, BEAUMONT ENTERPRISE (Jan. 1, 2020, 4:00 PM), <https://www.beaumontenterprise.com/news/article/Loophole-closed-in-Texas-law-designed-to-protect-14943691.php> [https://perma.cc/2BT8-E9LP].

of Texas.¹²³ Dr. Jason Terk, chair of the pro-medical provider lobbying group Texas Medical Association's (TMA) Council on Legislation, articulated this problem explicitly when he stated, "But keep in mind, a solution was coming down the pike one way or the other . . . this legislation impacts a minority of plans . . . [w]e're talking about non-ERISA . . . plans, which make up maybe about 15-20 percent of the market in most areas."¹²⁴ He is certainly correct that the state regulates a minority of health plans in Texas; even the TDI website states that SB 1264 "protects consumers with state-regulated health plans (about 16% of Texans) from surprise bills in emergencies and in cases where the consumer had no choice of providers."¹²⁵ That such a relatively small percentage of Texans stand to receive relief from SB 1264 is a limitation inherent in state legislative reform efforts; as mentioned previously, real change on the national level will require legislation from the federal government.¹²⁶ That said, SB 1264 will still have a significant effect on the plans that it does cover, and can serve as both template and example for the state and federal legislative reform efforts that will follow.

2. *Provider Concerns.*—The TMA has expressed other reservations about SB 1264, believing that it will make it more difficult for health care providers to receive payment for balance bills.¹²⁷ The TMA also indicated that the bill might not address the root causes of balance billing—Clayton Stewart, a lobbyist for TMA, stated that the root cause of balance billing lies in narrowing physician networks.¹²⁸ It is true that provider networks have become more narrow for some health plan options, and as a result, a patient's chances of being treated by an out-of-network provider have increased.¹²⁹ This can occur as a result of market forces, as insurers sometimes sell plans with narrowed networks in order to offer lower premiums to cost-conscious consumers.¹³⁰ However, while narrow networks do increase the risk of

123. Joey Berlin, *Swinging for Fairness: Law Creates New Ballgame for Surprise Billing*, TEX. MED. ASS'N (Aug. 2, 2019), <https://www.texmed.org/swingingforfairness/> [<https://perma.cc/TUU6-YC52>].

124. *Id.*

125. *State's Balance Billing Rules*, TEX. DEP'T OF INS. (June 22, 2020), <https://www.tdi.texas.gov/medical-billing/providers.html> [<https://perma.cc/8PJA-A956>].

126. *See supra* notes 35–39 and accompanying text. The U.S. Congress recently passed the No Surprises Act, which represents a comprehensive attempt to address balance billing at the federal level. Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Benedic Ippolito & Erin Trish, *Understanding the No Surprises Act*, BROOKINGS (Feb. 4, 2021), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/> [<https://perma.cc/3BBH-DW4X>].

127. Berlin, *supra* note 123.

128. *Id.*

129. HALL ET AL., *supra* note 76, at 12.

130. *Id.*

balance billing, they are certainly not the only cause.¹³¹ Other causes include more restrictive definitions of allowable charges, as well as more aggressive billing and collecting practices from providers.¹³² The tension between wider networks and cost-conscious consumers is certainly not going away any time soon, but this should not prevent consumers from being protected from surprise medical bills that they could not have reasonably avoided.

3. *Agency Capabilities.*—Institutional issues could also play a significant role in modulating SB 1264’s effectiveness. Specifically, the administrative capabilities of the state agencies assigned to support the reforms could pose a stumbling block to patients hoping to avail themselves of the bill’s protections. The TDI’s complaint processing department’s backlog of several thousand cases in the fall of 2018 is concerning, considering that the new regulatory regime is far more comprehensive, includes dual mediation and arbitration schemes, and requires much more than “entering complaints made by qualifying consumers, “[sending] [a]cknowledgment letters,” and “following up to make sure [the parties to the mediation] have the teleconference.”¹³³ Additionally, the TDI’s stated goals are to have the mediation process conclude within 245 days after the out-of-network provider receives the first claim payment from the insurer and to have the arbitration process conclude within 140 days after the first claim payment.¹³⁴ These deadlines and operational expenses represent a substantial burden on the state agencies tasked with implementing the bill. Unless the TMB and TDI are given sufficient resources to implement the mediation, arbitration, and enforcement provisions of SB 1264, the process for obtaining relief might be too slow to deliver the desired help to many Texan health service consumers.

4. *TDI Emergency Rules.*—The rules promulgated by the TDI seem to embody the spirit of the legislation and resolve the issues with the TMB’s proposed regulations. Since “emergency care” is not part of the exception under the TDI’s rules, the vast majority of involuntary balance billing issues should be eliminated.¹³⁵ The rules also mandate that out-of-network physicians cannot be assigned to a procedure without the patient’s explicit approval; this should include instances where an out-of-network

131. *Id.* at 13.

132. *Id.*

133. Root & Najmabadi, *supra* note 40; *see supra* subpart II(A).

134. TEX. DEP’T OF INS., *FAQ: Mediation and Arbitration Requirements and Processes*, *supra* note 88.

135. *See* Murphy, *supra* note 9 (describing a study, which found that emergency care makes up the majority of surprise bills).

anesthesiologist is assigned to the surgery by the provider.¹³⁶ Further, the inclusion of language requiring that the waiver be given to the patient as a stand-alone document serves to mitigate concerns that the provider could simply slip the form in with the many other documents that must be signed before obtaining medical services.¹³⁷ That said, the bill would be even more effective if it required that neutral consumer-support staff be present to explain the effects of the waiver (and of other forms) at hospitals allowing out-of-network providers to practice.¹³⁸

However, there are issues with the plain language of the TDI rules. It is not clear what is meant by a “meaningful choice” in the context. The TDI rules give one example of what is not a meaningful choice—assignment of an out-of-network provider by another provider or administrator—but neglect to further define the standard at the rule issuing stage.¹³⁹ Additionally, although a positive definition of coercion is given—charging nonrefundable fees prior to the signing of the waiver—it is not further defined either.¹⁴⁰ The new standards established by the emergency rules create ambiguity as to when patients could claim that they faced coercion or a lack of meaningful choice, and a clarification of these definitions could provide stronger protections for health care consumers. However, taken as a whole, these new rules serve to avert the controversy and are sufficiently protective that the narrow exception is unlikely to become a gaping loophole.¹⁴¹ One of the co-authors of SB 1264, State Senator Kelly Hancock, said that the bill was designed to be “patient-originated, patient-focused . . . [o]bviously you never know until [the new rules are] fully implemented, but it certainly seems like our concerns were addressed in the rulemaking from TDI.”¹⁴²

B. *The Texas Model as a National Template*

A comparison between SB 1264 and other state legislative attempts to combat balance billing supports the case for using the bill as a national template. New York is a useful state for this purpose, as it is comparable to Texas in population size and implemented its balance billing protections in

136. See 28 TEX. ADMIN. CODE § 21.4903 (2019) (prohibiting the assignment of out-of-network physicians to the consumer without explicit consumer approval).

137. See *id.* (requiring waiver notice be given in a stand-alone document).

138. Rachel Schwab, *The Texas Two-Step: Implementation of State Balance Billing Law Reveals Gaps in Consumer Protections*, GEO. UNIV. HEALTH POL'Y INST.: CTR. ON HEALTH INS. REFORMS (Feb. 3, 2020), <http://chirblog.org/texas-two-step-implementation-state-balance-billing-law-reveals-gaps-consumer-protections/> [<https://perma.cc/7QS9-JC5Q>].

139. See TEX. ADMIN. CODE § 21.4903 (defining meaningful choice with one negative example).

140. See *id.* (defining coercion with one positive example).

141. Goldenstein, *supra* note 122.

142. *Id.*

2015.¹⁴³ This has given policy makers several years of data to review. One of the primary criticisms of New York’s system, which also includes “baseball-style arbitration,” is that it has led to less savings and higher premiums for consumers.¹⁴⁴ The New York arbitration process often results in rates assessed at the eightieth percentile of what would be a normal rate for the service in the area.¹⁴⁵ These high arbitration awards then cost insurers more than they should have to pay and the higher costs are passed on to consumers through higher premiums.¹⁴⁶ Fortunately, the Texas plan has taken these concerns about the New York plan into account.¹⁴⁷

The TDI website makes this clear and explicitly delineates the two largest distinctions between the two systems.¹⁴⁸ The Texas reform does not define “usual and customary,” whereas “New York defines it as the 80th percentile of all charges.”¹⁴⁹ This is an important distinction, and will hopefully serve to insulate Texans from the higher premiums that New Yorkers are suffering. The broad list of factors which Texas arbitrators can consider in their decision, along with the system’s undefined standard for customary rates, should give arbitrators more latitude to make fair decisions that do not overcharge insurers. The second main distinction between the two states’ plans is also related to arbitration: the Texas system will require arbitrators that are knowledgeable about insurance and contract law, while the dispute resolution system in New York is performed by billing coders and physicians.¹⁵⁰ These individuals are potentially sympathetic to health care providers and may be more likely to award larger bills. Texas’s improvements on New York’s otherwise similar bill make SB 1264 a good candidate for more general implementation at the state level.

The case for SB 1264 as a national model is also supported by recent research on the subject.¹⁵¹ The Schaeffer Initiative for Innovation in Health Policy advises that, in order for a patient’s consent to out-of-network services to be valid, he or she should not be in an emergency situation, should have a case-specific costs estimate, and should have a meaningful choice between other feasible in-network options.¹⁵² Other than as discussed earlier, the

143. Bluth, *supra* note 94.

144. *Id.*

145. *Id.*

146. *Id.*

147. See *Senate Bill 1264: Protecting Consumers from Surprise Medical Bills*, TEX. DEP’T OF INS., <https://www.tdi.texas.gov/rules/2019/senate-bill-1264.html> [<https://perma.cc/H737-MTC6>] (last updated Aug. 8, 2020) (distinguishing the Texas law from the analogous New York law).

148. *Id.*

149. *Id.*

150. *Id.*

151. See HALL ET AL., *supra* note 76, at 28 (describing that “emerging experience” supports a SB 1264-style system for balanced billing).

152. *Id.* at 15.

TDI's newly adopted rules provide for this by preventing patients from being balance billed in an emergency context and by requiring that patients receive an estimate of the costs of the service and have a "meaningful choice" between in-network providers and out-of-network providers.¹⁵³ The report further mentions that the coercive elements inherent in a situation where a patient is forced to seek immediate medical care can be mitigated by ensuring that, before being balance billed, the patient is given an appropriate period of notice.¹⁵⁴ The rules established by the TDI require that the patient must sign the waiver ten business days before the operation, which should ensure that the patient has appropriate time to consider whether to proceed with the out-of-network provider.¹⁵⁵ The report also posits that the patient would ideally not be directly involved in the dispute resolution.¹⁵⁶ As mentioned earlier, this important recommendation has been adopted by SB 1264.¹⁵⁷

Another consideration is what process to use when establishing the correct payment amount for the surprise medical bill. The main alternative to "baseball-style arbitration" is referred to as "rate regulation."¹⁵⁸ Rate regulation systems are usually based off the rates that Medicare pays or the rates that health plans negotiate for within their networks.¹⁵⁹ What rate to use and what multiplier to apply is up to legislative discretion.¹⁶⁰ This system requires less of the administrative apparatus, but has the potential to become unmoored from the rates that are actually fair in a particular marketplace if the rate regulation benchmarks are not updated regularly.¹⁶¹ Although rate regulation is considered workable, "baseball-style arbitration" is usually considered to be one of the most effective methods for resolving balance billing issues at the state level.¹⁶² This is because it allows the arbitrator to make efficient decisions; he or she must only decide between two predetermined amounts rather than formulate an independent figure for the insurer to pay.¹⁶³ It also creates incentives to negotiate prior to the arbitration, as either side could end up losing and be forced to pay the full amount requested by the other side.¹⁶⁴ Finally, if the results of the arbitration are

153. 28 TEX. ADMIN. CODE §§ 21.4901, 21.4903 (2019).

154. See HALL ET AL., *supra* note 76, at 16 (suggesting that informed consent before treatment begins is useful).

155. TEX. ADMIN. CODE § 21.4903.

156. See HALL ET AL., *supra* note 76, at 26 n.35.

157. S. Comm. on Bus. & Commerce, Bill Analysis, Tex. S.B. 1264, 86th Leg., R.S. (2019), <https://capitol.texas.gov/tlodocs/86R/analysis/pdf/SB01264I.pdf> [<https://perma.cc/JX7J-ABT5>].

158. HALL ET AL., *supra* note 76, at 26.

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.* at 28.

163. *Id.* at 22.

164. *Id.*

recorded or otherwise made public, a body of informal precedent can develop to streamline the arbitration process and inform the parties as to what constitutes a customary rate.¹⁶⁵ Based on this, SB 1264 and the accompanying administrative rules have clearly been formulated to incorporate the recommendations of policy experts and health researchers, and it therefore represents one of the most recent and encompassing legislative attempts to fight surprise medical bills. It should be used as a model for other bills at the state level, so long as it is updated to ensure that it fully protects the victims of COVID-19.

C. *SB 1264 and COVID-19*

The global pandemic spreading across the United States has sharply accentuated the importance of SB 1264 and the urgency with which other states should consider implementing similar reforms. SARS-CoV-2—and the disease it causes, COVID-19—have swept across Texas and the nation, and protection against onerous medical bills are more important than ever. Whether or not SB 1264 will serve to protect the finances of sick patients is an important question for Texans and for health care consumers in other states that might use this bill as a framework for their own efforts.

Within the arena of the state health plans regulated by SB 1264, there has been some good news: the TDI reports that “Texas health insurers and health maintenance organizations are waiving consumer costs for medically necessary testing of COVID-19. Many also are offering telemedicine at no cost to consumers.”¹⁶⁶ Unfortunately, the agreement to waive co-pays for medically-necessary tests “does not include treatment for those diagnosed with the virus.”¹⁶⁷ This leads to the essential question of how SB 1264 can mitigate the costs associated with the actual treatment of COVID-19, which is likely to be far more expensive than the tests.

It is probable that SB 1264 as ratified and the TDI rules will cover most balance billing resulting from the pandemic, but will in only some cases prevent the utilization of the voluntary care exception to deny protections to patients for services related to treating COVID-19. SB 1264 and the TDI rules extend protections from balance billing to diagnostic and laboratory situations.¹⁶⁸ SB 1264 requires that: “Except as provided by Subsection (d),

165. *Id.*

166. *Texas Health Insurers Waiving Cost-Sharing for Testing*, TEX. DEP’T OF INS. (May 19, 2020), <https://www.tdi.texas.gov/news/2020/covid-19-health-plan-actions.html> [<https://perma.cc/7XSI-K7FV>].

167. Jeremy Blackman, *Coronavirus Testing Costs in Texas: What Patients Need to Know*, HOUS. CHRON. (Mar. 17, 2020), <https://www.houstonchronicle.com/news/health/article/Coronavirus-testing-costs-in-Texas-What-patients-15137911.php> [<https://perma.cc/3VES-RB46>].

168. Act of Sept. 1, 2019, 86th Leg., R.S., S.B. 1264, § 1.12 (codified at Tex. Ins. Code § 1551.230).

the administrator of a managed care plan . . . shall pay for a covered health care or medical service . . . provided . . . by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider.”¹⁶⁹ However, subsection (b) here makes a reference to subsection (d), which is the controversial voluntary exception.¹⁷⁰ The TDI rules confirm that SB 1264’s exceptions to the prohibitions against balance billing are applicable in non-emergencies when a consumer chooses to receive covered health care or medical services from a “diagnostic imaging provider or laboratory service provider that is not a participating provider for a health benefit plan.”¹⁷¹ In other words, the protections provided by SB 1264 can be waived in diagnostic and laboratory settings so long as the other requirements for the waiver are met.¹⁷² This means that someone being treated by their in-network physician (or at an in-network medical facility) could be given the waiver for an out-of-network laboratory provider, and then ten business days later be balance billed for the battery of laboratory tests associated with extended treatment of COVID-19. In that situation, the extent to which the patient could be balance billed would be determined by whether or not the laboratory and diagnostic tests are considered protected “emergency care.”¹⁷³ The rest of this subpart will primarily consider what might happen if an individual does have COVID-19, but it should be mentioned here that if extra tests beyond the covered initial evaluation ultimately come back negative, it is possible that the patient’s additional tests would not be considered part of “emergency care,” as defined by subsection 1301.155(a) of the Insurance Code, because there would not be an underlying medical condition affecting the patient’s health and the individual may not have actually been facing any “serious” medical threat.¹⁷⁴

These considerations lead to the larger question of whether the many other services provided to COVID-19 patients are covered by SB 1264 and protected from the voluntary care waiver. Since the waiver can be applied to “nonemergency health care,”¹⁷⁵ the question of what constitutes “emergency care” becomes especially important. “Emergency care” as used in the TDI rules “has the meaning assigned by section 1301.155” of the Texas Insurance Code.¹⁷⁶ Subsection (a) states in relevant part:

169. *Id.*

170. *Id.*

171. 28 TEX. ADMIN. CODE §§ 21.4901, 21.4903 (2019).

172. *Id.*

173. *Id.*

174. *See* TEX. INS. CODE ANN. § 1301.155(a) (defining “emergency care” as care to treat a sickness or injury that can lead to serious health consequences).

175. 28 TEX. ADMIN. CODE § 21.4901.

176. *See id* § 21.4902 (explaining how words and terms in the rules have the same meaning as in Texas Insurance Code Chapter 1467); TEX. INS. CODE ANN. § 1467.001 (stating that “emergency care” has the meaning assigned to it in section 1301.155 of the Texas Insurance Code).

In this section, “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.¹⁷⁷

The basic protections enshrined in the Texas Insurance Code by SB 1264 protect against balance billing for:

- (1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;
- (2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition;
- (3) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition.¹⁷⁸

The first protection appears apropos to testing for COVID-19; fortunately, the co-pay for such initial evaluations has been waived regardless.¹⁷⁹ The second protection would hopefully encompass the vast majority of immediate treatment for COVID-19, including most of the necessary tests. The third protection extends SB 1264’s basic coverage to “services originating in a hospital emergency facility . . . following treatment or stabilization[;]” as a result, COVID-19 treatment should be covered as “emergency care” under this subsection so long as the patient remains in a “hospital emergency facility or freestanding emergency care facility.”¹⁸⁰ Thus, it appears that SB 1264’s protections will apply to the vast majority of COVID-19 treatments, so long as the treatment is confirmed as emergency

177. TEX. INS. CODE ANN. § 1301.155 (emphasis added).

178. *Id.*

179. *See id.* (requiring payment of copays for emergency care); *Texas Health Insurers Waiving Cost-Sharing for Testing*, *supra* note 166 (waiving costs related to COVID-19 testing).

180. TEX. INS. CODE ANN. § 1301.155.

care or no waiver is signed.¹⁸¹ However, many patients with COVID-19 suffer from lingering health problems,¹⁸² which might not meet the criteria listed above in section 1301.155 because the complications occur at a later time or different location than evaluation and stabilization or might not match one of the enumerated list of “serious” results. Protections against balance billing for the medical care provided to treat these health effects could thus potentially be waived since the treatment would not be considered “emergency care” under the TDI’s rules.

A patient suffering prolonged health problems ancillary to COVID-19 is certainly in no position to carefully read and understand all the documents he or she is likely to be presented with. It seems that, were out-of-network providers so inclined, they could easily abuse SB 1264’s waiver exception under these conditions for patients recovering from COVID-19 without formally violating the patients’ rights under the TDI rules to “meaningful choice” or freedom from “coercion.”¹⁸³ One hopes that out-of-network providers will choose not to request waivers from their patients in such situations, but the TDI rules do not seem to forbid it *prima facie*.

Taken together, the protections provided by SB 1264 should provide strong protections for patients getting tested and treated for COVID-19, but the bill’s plain language and the TDI rules create a loophole for abuse of the waiver system in situations that most would still consider involving “emergency care.”

In considering SB 1264’s viability as a national template, it is important to weigh the protections that it provides for COVID-19 patients against the protections provided by other states. In fact, ambiguity over what services exactly are covered by balance billing protections during the pandemic has not been limited to Texas. New Mexico and Colorado, which both also have balance billing protections, have acted decisively to resolve the issue.¹⁸⁴ Both states officially designated the treatment of COVID-19 and its symptoms as “emergency care,” thus eliminating the ambiguity still present in Texas’s protections.¹⁸⁵ New York recently reminded insurers that the state protections

181. *See* 28 TEX. ADMIN. CODE § 21.4903 (2019) (permitting waiver, which would deny protections).

182. Pam Belluck, *Here’s What Recovery from Covid-19 Looks Like for Many Survivors*, N.Y. TIMES (July 1, 2020), <https://www.nytimes.com/2020/07/01/health/coronavirus-recovery-survivors.html> [<https://perma.cc/D3GD-QGG6>].

183. *See* TEX. ADMIN. CODE § 21.4903 (clarifying the terms “meaningful choice” and “coercion” with examples).

184. Jack Hoadley, Maanasa Kona & Kevin Lucia, *States Can Prevent Surprise Bills for Patients Seeking Coronavirus Care*, COMMONWEALTH FUND (Apr. 29, 2020), <https://www.commonwealthfund.org/blog/2020/states-can-prevent-surprise-bills-coronavirus-care> [<https://perma.cc/29N8-FF75>].

185. *Id.*

against surprise medical bills apply fully to COVID-19 patients.¹⁸⁶ Even some states with no comprehensive balance billing protections, such as Utah, Wisconsin, and Ohio, have passed legislative stopgaps that limit the amount patients can be charged for out-of-network COVID-19 treatment.¹⁸⁷

Texas, however, has not yet moved to substantively update or clarify its balance billing protections for COVID-19 patients. The TDI released a bulletin stating that “[w]hen a network provider is not reasonably available, carriers must ensure that the consumer is protected, as contemplated by . . . Texas’s laws.”¹⁸⁸ This is a disappointing equivocation, especially in light of the leadership shown by New Mexico and Colorado. It is not clear what “reasonably available” means, and as discussed above, Texas’s laws leave room for uncertainty on whether protections can be waived for continuing COVID-19 care.

Now is not the time for uncertainty. SB 1264 was designed to be one of the strongest state balance billing protections in the country. Texas’s leadership on this issue should not be ceded by a failure to adequately clarify the protections available to COVID-19 patients. The easiest way to ameliorate the situation would be for the TDI to issue emergency rules in the same vein as the declarations and bulletins from New Mexico and Colorado; simply clarifying that all treatment for COVID-19 and its ancillary symptoms constitutes “emergency care” would delineate the scope of the protections enshrined by SB 1264 and prevent the possibility of waivers being given to COVID-19 patients. A legislative or agency declaration specifically preventing balance billing for the treatment of COVID-19 and its continuing symptoms would be more complicated, but would also serve to explicitly protect patients.

SB 1264 is a well-designed and well-researched bill that incorporates policy alongside case data from other states. The powerful protections it and the associated TDI rules provide should be used as a framework for other states in the fight against surprise medical bills. Further, Texas should not relinquish its position as a leader in protecting health care consumers by leaving ambiguous whether continuing treatment for COVID-19 patients is properly defined as nonwaivable “emergency care.” Once the issue is

186. *Id.*

187. See AM. MED. ASS’N, ISSUE BRIEF: BALANCE BILLING FOR COVID-19 TESTING AND CARE - FEDERAL AND STATE RESTRICTIONS 3 (2020), <https://www.ama-assn.org/system/files/2020-05/issue-brief-balance-billing-covid-19-testing-care.pdf> [<https://perma.cc/Z4WQ-6PE8>] (describing the legislative measures taken by Utah, Wisconsin, and Ohio); Maanasa Kona, *State Balance-Billing Protections*, COMMONWEALTH FUND (Nov. 30, 2020), <https://www.commonwealthfund.org/publications/maps-and-interactives/2020/sep/state-balance-billing-protections> [<https://perma.cc/XUZ4-7K5C>] (providing a map of U.S. states with and without billing protection legislation and showing that Utah, Wisconsin, and Ohio all lack billing protection).

188. TEX. DEP’T OF INS., COMMISSIONER’S BULLETIN #B-0017-20 (2020), <https://www.tdi.texas.gov/bulletins/2020/B-0017-20.html> [<https://perma.cc/95K7-KM7U>].

clarified, Texas's bipartisan effort at reforming balance billing will be ready to serve as what it was intended to be—the archetype for other states to follow.

Conclusion

The practice of balance billing is a serious problem for America's health care system.¹⁸⁹ Many states have developed or are developing potential solutions to the problem and making choices about what types of legislation best protect patients while fairly considering the interests of healthcare providers and insurers.¹⁹⁰ The Texas system of informal resolution and mediation was relatively effective when it was used, but it was plagued by a lack of resources, a large backlog, and few formally enshrined protections for patients.¹⁹¹ SB 1264 has radically transformed how balance bills are treated in Texas and provides a comprehensive mediation and arbitration process for resolving the bills.¹⁹² The reforms that SB 1264 brings to the table go a long way towards solving the problems with the old system, and its provisions should protect patients from the vast majority of surprise medical bills.¹⁹³ However, the reform faces institutional, procedural, and practical challenges that may limit its effectiveness. Further, while the bill provides strong protections for patients in most situations where balance billing can occur, the ambiguity over how COVID-19 and its continuing symptoms are treated under the existing framework could potentially become a serious issue for Texans if the issue is not clarified.

These challenges are formidable, but SB 1264 is overall a well-written and carefully researched effort by state lawmakers that adequately considers findings from policy advocates, experts, case studies, and stakeholders, and should provide Texans with a powerful remedy to the problem of balance billing.¹⁹⁴ More than that, SB 1264 should give other states a valuable template on which to base their own balance billing legislation, so long as they carefully consider how best to implement the elements of this reform that carry the highest potential for abuse.¹⁹⁵

189. *See generally* Rosenthal, *supra* note 3 (describing the crippling surprise bills faced by Americans).

190. *See* Lopez, *Faced with Surprise Medical Bills, Some Texans Have Recourse*, *supra* note 55 (explaining that states have moved toward creating systems that make life easier for consumers).

191. *Id.*; Root & Najmabadi, *supra* note 40.

192. Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, *supra* note 6.

193. *See id.* (describing the legislation's impact as removing the insured from the dispute, and forcing the insurance company and medical providers to agree on a fair price).

194. *TDI Relies on Best Practices Approach to Develop Arbitration Program*, TEX. DEP'T OF INS., <https://www.tdi.texas.gov/news/2020/tdi01222020.html> [<https://perma.cc/DQA4-9H3J>].

195. Lopez, *Texas Is Latest State to Attack Surprise Medical Bills*, *supra* note 6 (describing how the Texan reform effort can influence reform efforts nationally).