

A General Overview of SB 1264 (86th Texas Legislature) and Texas' New Arbitration Process for Certain Out-of-Network Claims¹

Applicability

- **Affected health plans:**

- The following state-regulated health plans²:
 - A health plan offered by an HMO operating under Chapter 843, Texas Insurance Code;
 - A preferred provider benefit (PPO) plan or exclusive provider benefit (EPO) plan offered by an insurer under Chapter 1301, Texas Insurance Code; and
- Managed care plans provided under: (1) the group benefits program in Chapter 1551 of the Texas Insurance Code;³ (2) the group program in Chapter 1575 of the Texas Insurance Code;⁴ or (3) Chapter 1579 of the Texas Insurance Code.⁵

- **Affected Out-of-Network Services and Supplies:**

- The following out-of-network services and supplies if they are covered services or supplies received by an enrollee in one of the affected health plans described above:
 - “covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider;”⁶
 - “a covered health care ... service performed for or covered supply related to that service provided to an enrollee by an out-of-network provider who is a **facility-based provider**⁷ ... if the provider performed the service at a health care facility that is a network provider;”⁸ and
 - “a covered health care ... service performed for or a covered supply related to that service provided to an enrollee by an out-of-network **diagnostic imaging provider**⁹ or **laboratory**

¹ Note that this document is for general informational purposes only. It is only a summary of the bill and is not intended to be an exhaustive discussion of the bill. Certain provisions of the bill (e.g., the study provisions and mediation provisions) are not discussed in this document. The touchstone for compliance will be the actual language of the [law](#) itself, as well as applicable rules implementing the law. Various state agencies, including the Texas Department of Insurance (TDI) and the Texas Medical Board (TMB) will be promulgating rules to implement SB 1264. As of the publication date of this summary (i.e., December 19, 2019), TDI has adopted two sets of rules implementing SB 1264. See “Rulemaking” section in this document for more information regarding those rules. Additionally, please check the Texas Register and Texas Administrative Code regularly for any relevant rules that may be promulgated after the publication date of this document.

² An identification card issued to enrollees of one of these state-regulated HMO, PPO, or EPO plans is required to have the letters “TDI” or “DOI” on the front of the card. See 28 TAC § 21.2820 available at: [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=T&app=9&p_dir=P&p_rloc=165919&p_tloc=&p_ploc=1&pg=3&p_tac=&ti=28&pt=1&ch=21&rl=2820](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=P&p_rloc=165919&p_tloc=&p_ploc=1&pg=3&p_tac=&ti=28&pt=1&ch=21&rl=2820)

³ See §§ 1551.003(15), 1551.015, 1551.228, 1551.229, and 1551.230 for more information. Chapter 1551 is the Texas Employees Group Benefits Act.

⁴ See §§ 1575.002(8), 1575.009, 1575.171, 1575.172, and 1575.173 for more information. Chapter 1575 is the Texas Public School Retired Employees Group Benefits Act.

⁵ See §§ 1579.002(8), 1579.009, 1579.109, 1579.110, and 1579.111 for more information. Chapter 1579 is the Texas School Employees Uniform Group Health Coverage Act.

⁶ For more information on the scope of the out-of-network emergency care provisions, see Tex. Ins. Code § 1271.155 (HMO); § 1301.0053 (EPO); § 1301.155 (PPO); § 1551.228; § 1575.171; and § 1579.109.

⁷ Under Tex. Ins. Code §§ 1271.157, 1301.164, 1551.229, 1575.172, and 1579.110, a “facility-based provider” means: “a physician or [health care] provider who provides health care [or medical] services to patients of a health care facility.”

⁸ *Id.*

⁹ Under Tex. Ins. Code §§ 1271.158, 1301.165, 1551.230, 1575.173, and 1579.111, a “diagnostic imaging provider” means a “health care provider who performs a diagnostic imaging service on a patient for a fee or interprets imaging produced by a diagnostic imaging service.” Under Tex. Ins.

service provider¹⁰ ... if the provider performed the service in connection with a health care service performed by a network provider.”¹¹

- **Effective Date:** SB 1264 only applies to one of the above health care services or supplies provided on or after January 1, 2020.¹² “A health care ... service or supply provided before January 1, 2020, is governed by the law in effect immediately before the effective date of [the] Act....”¹³

Health Plan Payment Requirement

Each affected health plan issuer (described above) is required to pay the out-of-network provider at the usual and customary rate or at an agreed rate for a covered out-of-network service or supply described above that is provided to an enrollee of the plan. The health plan issuer is required to make this payment “directly to the provider not later than, as applicable: (1) the 30th day after the date the [plan issuer] receives an electronic clean claim ... for those services that includes all information necessary for the [plan issuer] to pay the claim; or (2) the 45th day after the date the [plan issuer] receives a non-electronic clean claim ... for those services that includes all information necessary for the [plan issuer] to pay the claim.”¹⁴ If the out-of-network provider is not satisfied with this initial payment, the provider may request arbitration (if the provider is not a facility) or mediation (if the provider is a facility).¹⁵ *For more information on arbitration, see basic steps on the arbitration process, below.*

Prohibition on Balance Billing*

“[An out-of-network provider] or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a [service or supply described above] in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee’s health ... plan that: (1) is based on: (A) the amount initially determined payable by [the health plan issuer]; or (B) if applicable, a modified amount as determined under the [plan issuer’s] internal appeal process; and (2) is not based on any additional amount to be owed to the provider under Chapter 1467 [which is the arbitration and mediation chapter].”¹⁶

***Exception to Balance Billing Prohibition and Health Plan Payment Requirements under SB 1264**

The above health plan payment requirements and prohibitions on balance billing do not apply to a service described above if the service is “a nonemergency health care service:

- (1) that an enrollee elects to receive in writing in advance of the service with respect to each [out-of-network] provider providing the service; and
- (2) for which [an out-of-network] provider, before providing the service, provides a complete written disclosure to the enrollee that:
 - (A) explains that the 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

Code § 1467.001(2-b), a “Diagnostic imaging service” means “magnetic resonance imaging, computed tomography, positron emission tomography, or any hybrid technology that combines any of these imaging modalities.”

¹⁰ Under Tex. Ins. Code §§ 1271.158, 1301.165, 1551.230, 1575.173, and 1579.111, “Laboratory service provider” means “an accredited facility in which a specimen taken from a human body is interpreted and pathological diagnoses are made or a physician who makes an interpretation of or diagnosis based on a specimen or information provided by a laboratory based on a specimen.”

¹¹ *Id.*

¹² SECTION 5.01 of SB 1264.

¹³ *Id.*

¹⁴ See Tex. Ins. Code §§ 1271.155(a) and (f), 1271.157(b), 1271.158(b), 1301.0053(a), 1301.155(b), 1301.164(b), 1301.165(b), 1551.228(b), 1551.229(b), 1551.230(b), 1575.171(b), 1575.172(b), 1575.173(b), 1579.109(b), 1579.110(b), and 1579.111(b).

¹⁵ Note that Tex. Ins. Code § 1467.002 specifically provides that Chapter 1467 (i.e., the mediation/arbitration chapter) “applies to (1) a health benefit plan offered by a health maintenance organization operating under Chapter 843; (2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and (3) an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.”

¹⁶ See Tex. Ins. Code §§ 1271.155(g), 1271.157(c), 1271.158(c), 1301.0053(b), 1301.155(d), 1301.164(c), 1301.165(c), 1551.228(c), 1551.229(c), 1551.230(c), 1575.171(c), 1575.172(c), 1575.173(c), 1579.109(c), 1579.110(c), and 1579.111(c).

- (C) discloses the circumstances under which the enrollee would be responsible for those amounts.”¹⁷

NOTE: The above language regarding the exception to SB 1264’s balance billing prohibition and payment requirements is taken from the statutory language of SB 1264. In order to use the exception referenced above, additional/different requirements beyond those listed above must be satisfied under applicable rules. See “Rulemaking” discussion, below, for more information. Also note that if an out-of-network provider uses this exception, he or she is not eligible to participate in arbitration.

Additional Health Plan Issuer EOB Requirements under SB 1264

An issuer of a health benefit plan described above is required to provide written notice that includes the following elements in an explanation of benefits (EOB) provided to the enrollee and the provider “in connection with a ... health care service or supply provided by an out-of-network provider”:

- “a statement of the balance billing prohibition ... , as applicable;
- the total amount the provider may bill the [enrollee] under the [enrollee’s plan] and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and
- for an explanation of benefits provided to the provider, information required by [Texas Department of Insurance (TDI)] commissioner rule advising the provider of the availability of mediation [if the provider is a facility] or arbitration [if the provider is not a facility], as applicable...”¹⁸

The EOB with the above notice must be provided “to a provider not later than the date the [health plan issuer] makes a payment under the applicable section of the law.”¹⁹ See the timeframe discussed in “Health plan payment requirement,” above.

Some of the basic steps in the arbitration process for claims submitted by out-of-network physicians and other out-of-network providers who are not facilities for the above-described services and supplies under SB 1264²⁰

(Note: Under SB 1264, out-of-network facilities will go through a revised mediation process, not arbitration)

1. **Timeframe for arbitration request and eligibility for arbitration.** “Not later than the 90th day after the date an out-of-network provider receives the initial payment for a health care ... service or supply, the ... provider or the [issuer/administrator of an affected health plan]²¹ may request arbitration of a settlement of an out-of-network health benefit claim through a portal on [TDI’s] website if: (1) there is a charge billed by the provider and unpaid by the issuer or administrator after copayments, coinsurance, and deductibles for which an enrollee [of that plan] may not be billed; and (2) the health benefit claim is for: (A) [out-of-network] emergency care; (B) a health care service or supply provided by [an out-of-network] facility-based provider in a [network facility]; (C) an out-of-network laboratory service; or (D) an out-of-network diagnostic imaging service.”²² “The person who requests the arbitration [is required to] provide written notice on the date the arbitration is requested in the form and manner prescribed by [TDI] commissioner rule to: (1) [TDI]; and (2) each other party.”²³
2. **Claims bundling.** Multiple claims may be bundled together for submission in one arbitration proceeding within the timeframe described in 1. above; however, TDI rules are required to “provide that the total amount in

¹⁷ See Tex. Ins. Code §§ 1271.157(d), 1271.158(d), 1301.164(d), 1301.165(d), 1551.229(d), 1551.230(d), 1575.172(d), 1575.173(d), 1579.110(d), and 1579.111(d).

¹⁸ Tex. Ins. Code §§ 1271.008, 1301.010, 1551.015, 1575.009, and 1579.009.

¹⁹ Tex. Ins. Code §§ 1271.008, 1301.010, 1551.015, 1575.009, and 1579.009.

²⁰ Again, note that this is not intended to be all-inclusive. Additionally, note that TDI has [adopted rules](#) regarding the arbitration process that impose additional/different requirements than the statutory requirements listed here. Please review those rules, as the touchstone for compliance will be both the language of the law and applicable regulations. See “Rulemaking” section, below in this document, for more information. Please also note that under Tex. Ins. Code §1467.087(c), on agreement of all parties, any deadline under the arbitration subchapter may be extended.

²¹ Note that Tex. Ins. Code § 1467.002 specifically provides that Chapter 1467 (i.e., the mediation/arbitration chapter) “applies to (1) a health benefit plan offered by a health maintenance organization operating under Chapter 843; (2) a preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer under Chapter 1301; and (3) an administrator of a health benefit plan, other than a health maintenance organization plan, under Chapter 1551, 1575, or 1579.”

²² Tex. Ins. Code § 1467.084(a).

²³ Tex. Ins. Code § 1467.084(c).

controversy for multiple claims in one proceeding may not exceed \$5,000; and ... multiple claims in one proceeding must be limited to the same out-of-network provider.”²⁴

3. **Mandatory participation.** Once arbitration is requested, the health benefit plan issuer/administrator and the provider (or the provider’s representative) are required to participate in the arbitration process;²⁵ however, the parties may reach a settlement prior to completion of the full arbitration process. The enrollee is not a part of the arbitration process.
4. **Arbitrator selection and costs.** “If the parties do not select an arbitrator by mutual agreement on or before the 30th day after the date the arbitration is requested, the party requesting the arbitration [is required to] notify the [TDI] commissioner, and the commissioner [is required to] select an arbitrator from the commissioner’s list of approved arbitrators.”²⁶ The parties are required to “evenly split and pay the arbitrator’s fees and expenses.”²⁷
5. **Required informal settlement teleconference.** “In an effort to settle the claim before arbitration, all parties [are required to] participate in an informal settlement teleconference not later than the 30th day after the date on which the arbitration is requested.”²⁸
6. **Timeframe for entire arbitration process.** If a claim goes through the full arbitration process, the entire process (from the request up to the arbitrator’s provision of a written decision to the parties) must be completed within 51 days after the request.²⁹ This includes the 30 days described in 5. above.
7. **Arbitration determination factors.** “The arbitrator [will] set a date for submission of all information to be considered by the arbitrator.”³⁰ “The only issue that an arbitrator may determine is the reasonable amount for the health care ... services or supplies provided to the enrollee by an out-of-network provider.”³¹ “The determination must take into account:
 - (1) whether there is a gross disparity between the fee billed by the out-of-network provider and:
 - (A) fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and
 - (B) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;
 - (2) the level of training, education, and experience of the out-of-network provider;
 - (3) the out-of-network provider’s usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider;
 - (4) the circumstances and complexity of the enrollee’s particular case, including the time and place of the provision of the service or supply;
 - (5) individual enrollee characteristics;
 - (6) the 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database [selected by TDI];
 - (7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database [selected by TDI];

²⁴ Tex. Ins. Code § 1467.084(e).

²⁵ Tex. Ins. Code § 1467.084(b).

²⁶ Tex. Ins. Code § 1467.086(a). See also § 1467.086(b), (c), and (d) for additional provisions on arbitrator selection by the commissioner and commissioner approval of arbitrators.

²⁷ Tex. Ins. Code § 1467.087(e).

²⁸ Tex. Ins. Code § 1467.084(d). Note also that the law provides that a health benefit plan issuer or administrator, as applicable is required to make a reasonable effort to arrange the teleconference.

²⁹ Tex. Ins. Code § 1467.088(a).

³⁰ Tex. Ins. Code § 1467.087(a). Also note that under §1467.087(b) a party is not permitted to engage in discovery in connection with an arbitration. Under subsection (d) unless the parties agree otherwise, an arbitrator is not permitted to determine whether a health benefit plan covers a particular health care service or supply. Under subsection (f) information submitted by the parties to the arbitrator is confidential and not subject to disclosure under Chapter 552, Government Code.

³¹ Tex. Ins. Code § 1467.083(a).

- (8) the history of network contracting between the parties;
- (9) historical data for the percentiles described by ... (6) and (7); and
- (10) an offer made during the [required] informal settlement teleconference...³²

8. Arbitrator decision.

- (1) The arbitrator will then determine whether the billed charge or the payment made by the health plan issuer/administrator, as those amounts were last modified during the issuer's or administrator's internal appeal process, if the provider elects to participate, or the required informal settlement teleconference, as applicable, is the closest to the reasonable amount for the services or supplies (determined in accordance with the factors above).³³
- (2) The arbitrator will select the amount determined to be the closest under (1) as the binding award amount.³⁴
- (3) The arbitrator is required to provide written notice in the form and manner provided by TDI commissioner rule of the reasonable amount for the services or supplies and the binding award amount. If the parties settle before a decision, the parties are required to provide written notice in the form and manner prescribed by TDI commissioner rule of the amount of the settlement. TDI is required to maintain a record of these notices.³⁵

9. **Effect of Decision and Payment of Any Additional Amount.** "An arbitrator's decision ... is binding."³⁶ "Not later than the 30th day after the date of an arbitrator's decision ..., a health benefit plan issuer or administrator [is required to] pay an out-of-network provider any additional amount necessary to satisfy the binding award."³⁷ "Not later than the 45th day after the date of an arbitrator's decision ..., a party not satisfied with the decision may file an action to determine the payment due to an out-of-network provider."³⁸ In such an action, "the court [will] determine whether the arbitrator's decision is proper based upon a substantial evidence standard of review."³⁹

Requirements of the Benchmarking Database Selected by TDI

TDI is required to "select an organization to maintain a benchmarking database...⁴⁰ "The organization may not: (1) be affiliated with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider; or (2) have any other conflict of interest."⁴¹ "The benchmarking database must contain information necessary to calculate, with respect to a health care ... service or supply, for each geozip area in this state: (1) the 80th percentile of billed charges of all physicians or health care providers who are not facilities; and (2) the 50th percentile of rates paid to participating providers who are not facilities."⁴² "The [TDI] commissioner may adopt rules governing the submission of information for the benchmarking database...⁴³

Enforcement Provisions – Disciplinary Actions and Attorney General Actions

Disciplinary actions against physicians and other providers:

"An appropriate regulatory agency that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that

³² Tex. Ins. Code § 1467.083(b).

³³ Tex. Ins. Code § 1467.088(a)(1). (Note that under subsection (a), the written decision is required to be provided to the parties not later than the 51st day after the date the arbitration is requested.)

³⁴ Tex. Ins. Code § 1467.088(a)(2).

³⁵ Tex. Ins. Code § 1467.088(c).

³⁶ Tex. Ins. Code § 1467.089(a).

³⁷ Tex. Ins. Code § 1467.089(d).

³⁸ Tex. Ins. Code § 1467.089(b).

³⁹ Tex. Ins. Code § 1467.089(c).

⁴⁰ Tex. Ins. Code § 1467.006(b).

⁴¹ Tex. Ins. Code § 1467.006(b).

⁴² Tex. Ins. Code § 1467.006(c).

⁴³ Tex. Ins. Code § 1467.006(d).

prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition."⁴⁴

Disciplinary actions against health benefit plan issuers or administrators:

"[TDI] may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure."⁴⁵

Attorney general actions:

"If the attorney general receives a referral from the appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition, the attorney general may bring a civil action in the name of the state to enjoin the individual or entity from the violation."⁴⁶

"If the attorney general prevails in an action [described above], the attorney general may recover reasonable attorney's fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action."⁴⁷

Bad Faith participation:

"Bad faith participation or otherwise failing to comply with [the arbitration subchapter] is grounds for imposition of an administrative penalty by the regulatory agency that issued the license or certificate of authority to the party who committed the violation."⁴⁸

"The following conduct constitutes bad faith participation for purposes of [Chapter 1467 of the Insurance Code]: (1) failing to participate in the informal settlement teleconference ... or an arbitration ... under [Chapter 1467]; (2) failing to provide information the arbitrator ... believes is necessary to facilitate a decision or agreement; or (3) failing to designate a representative participating in the arbitration ... with full authority to enter into any agreement."⁴⁹

Rulemaking

Note that the language above is a summary of the statutory language of SB 1264 (**and does not include a summary of the related rules**). The touchstone for compliance with SB 1264 will be the statutory language, as well as any applicable rules implementing the law. It is, therefore, very important to review [SB 1264](#) itself and rules implementing SB 1264 in order to comply with the requirements of the law (**as the rules impose additional/different requirements beyond those stated in the law itself**).

Various state agencies will be promulgating rules to implement SB 1264. As of the publication date of this summary, TDI has adopted two sets of rules implementing SB 1264:

⁴⁴ Tex. Ins. Code § 752.003(a).

⁴⁵ Tex. Ins. Code § 752.003(b).

⁴⁶ Tex. Ins. Code § 752.002(a).

⁴⁷ Tex. Ins. Code § 752.002(b).

⁴⁸ Tex. Ins. Code § 1467.102(a).

⁴⁹ Tex. Ins. Code § 1467.101(a).

- On December 3, TDI filed an [adoption order](#) for its rules (i.e., amended 28 TAC §§ 21.5001-21.5003, 21.5010-21.5013, 21.5030 and new §§ 21.5040, 21.5020-21.5023, and 21.5050) implementing the following components of SB 1264: (1) the arbitration process under SB 1264 (as well as the mediation process), (2) TDI's complaint resolution process, (3) explanation of benefit requirements, and (4) requirements related to benchmarking. Please review the adoption order for more information. The actual adopted rule language begins at the bottom of page 98 of the adoption order (where it says "TEXT"). TDI's adoption order for this set of rules will be published in the Dec. 20 edition of the Texas Register. These TDI rules will be effective on December 23, 2019 and except as provided in 28 TAC §21.5050 (relating to health benefit plan issuer/administrator submission of information) apply to a claim for certain services or supplies provided on or after January 1, 2020.
- On December 18, 2019, TDI issued an [emergency adoption order](#) for its rules (i.e., 28 TAC §§21.4901-21.4904) implementing SB 1264's exception to the prohibition on balance billing. This [emergency rule](#) and the [related form](#) are effective on January 1, 2020. The actual adopted rule language begins on the bottom of page 6 of the adoption order (where it says "TEXT"). These rules (and the related form) may be revised by TDI at some point, since they were adopted as emergency rules. TDI has stated that "[t]he agency soon will post the rule through the normal rulemaking process, which will allow time to accept and consider public comments."
 - On December 18, 2019, the TMB issued "[TMB Guidance Statement on TDI Rules Related to Senate Bill 1264](#)," which explains, among other things, that "Physicians and practitioners, under the authority and oversight of TMB, who seek to exercise the exceptions to the prohibitions against balance billing must comply with all provisions of SB 1264, including as interpreted by TDI rules." The TMB Guidance Statement also explains the TMB's enforcement authority related to violations of SB 1264 and notes that the "TMB will work on development of rules consistent with TDI's rules."

Please check the Texas Register and Texas Administrative Code regularly for relevant rules after the publication date of this document. Any additional rules or rule amendments (when adopted and effective) may impact the implementation of the statutory provisions discussed in this document and may impose additional/different regulatory requirements beyond those discussed in this document.

Questions

If there are questions about complying with the requirements of SB 1264 and applicable regulations, one should review the law and regulations and consult with a privately-retained attorney.

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