

September 9, 2020

Via electronic submission to: Sergio.Cavazos_HC@house.texas.gov

House Committee on Insurance
Rep. Eddie Lucio III, Chair

PUBLIC COMMENT LETTER

Re: Texas Hospital Association Response to Interim Charge #1: Implementation of Senate Bill 1264 (Surprise Billing)

Dear Honorable Members of the House Committee on Insurance:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide responses to the House Committee on Insurance's formal request for information regarding the implementation of Senate Bill 1264, 86th R.S. Texas hospitals have been at the front lines of the COVID-19 pandemic, and information regarding the implementation of SB 1264 is still forthcoming. However, THA offers the following response and will gladly furnish additional information, including information related to the COVID-19 Public Health Emergency, when available.

1. The Texas Department of Insurance has interpreted SB 1264 to require agreement between the parties to mediate multiple facility claims before the same mediator. Title 28 Tex. Admin. Code § 21.5011(g) states, "The parties may agree to aggregate claims between the same facility and same health benefit plan issuer or administrator for mediation." The result is the default to require claims to be mediated one at a time before individual mediators at significant expense for both the facility and the payor. As a practical consideration, facilities are the parties requesting mediation because the payor has the unique initial remedy to pay a claim at a lower rate. Therefore, the facility is requesting both mediation and the ability to mediate multiple claims. The payor can deny the request to mediate multiple claims, which creates a per-claim penalty of the expense of a mediator and a significant backlog of claims. Mediating multiple claims (known as bundling or batching) should not require agreement between the payor and the facility. THA recommends a clarification to the law that permits the party who requests mediation to "batch" multiple claims before a single mediator, which would create efficiency in dispute resolution, use of fewer mediators and decreased cost. Chapter 1467 of the Insurance Code should state that the party requesting mediation may elect to mediate multiple claims without agreement from the other party for dates of service during a static time period—for instance, one year or six months.
2. THA has consistently expressed concern regarding a policy by certain health plans of determining whether a patient's condition qualifies as an emergency based on the patient's final diagnosis, rather than the

patient's presenting symptoms. This runs contrary to accepted medical standards and even to the interpretation of the Texas Department of Insurance. In a January 7 letter to the health plans of Texas,¹ Texas Department of Insurance Commissioner Kent Sullivan wrote, "Claim denials based on a failure to meet the prudent layperson standard for emergency care must be based on a review of the patient's presenting symptoms, not on the later diagnosis code." As health benefit plans issue policies in this state and around the country that scrutinize the validity of emergency claims, THA proposes a clarification to the "prudent layperson" standard to require health plans to determine whether patients qualify for emergency care based on their presenting symptoms, not their ultimate diagnoses. Texas' robust surprise medical billing law applies to emergency care visits at facilities. If health benefit plan issuers disagree on whether the visit is emergent in the first place, the claims resolution process is left uncertain to the detriment of consumers, facilities and payors.

3. Adequate and accurate health benefit plan networks are paramount to preventing surprise medical bills from occurring in the first place. Often, provider directories list providers as participating providers in a health benefit plan at the time a consumer selects the plan. However, after the consumer becomes an enrollee, but prior to the expiration of the enrollee's contract, the provider may become out of network. To ensure that consumers get the benefit of their bargain, if a provider is listed as "in-network" at the time a consumer selects a plan, but later becomes "out-of-network," THA recommends a legislative solution for the health benefit plan issuer to pay the provider's charges at the in-network rate and to limit the enrollees responsibility to in-network cost sharing. Some exceptions would be necessary to prevent inequity, such as exceptions for lapse in a provider's licensure and unilateral termination of a contract with a health benefit plan issuer by a provider.

THA has been heavily involved in the SB 1264 rulemaking process at the Texas Department of Insurance and has provided both oral and written testimony. Attached, please find copies of THA's written testimony, which is indicative of many of the facility challenges related to implementation of the bill.

Again, thank you for the opportunity to respond to this request for information. Please do not hesitate to contact me directly with questions at 512/465-1539 or cduncan@tha.org.

Respectfully submitted,

/s/ D. Cameron Duncan III

D. Cameron Duncan III
Associate General Counsel
Texas Hospital Association

¹ <https://www.tdi.texas.gov/medical-billing/letter-to-health-plans.html>