Texas Hospital Association

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COMMENT LETTER

Re: Texas Hospital Association Comments on Surprise Billing Legislation: HB 2967 (Rep. Oliverson); SB 1591 (Sen. Whitmire); SB 1264 (Sen. Hancock); and HB 3933 (Rep. Martinez Fischer)

The Texas Hospital Association is committed to a solution to surprise billing that protects consumers from surprise medical bills for emergency or unplanned health care services without interrupting the contracts already in place between health plans and facilities. From the outset, THA testified in support of Sen. Hancock's bill (Senate Bill 1264, first committee substitute) that transferred the current consumer-initiated mediation process to one between only the health plan and out-of-network provider. Despite resource limitations at the Texas Department of Insurance, mediation has worked well in Texas for hospitals. THA supports a mediation process that shields consumers from responsibility for out-of-network emergency medical bills beyond their known cost-sharing amounts, such as coinsurance, copayments and deductibles.

The most recent version of SB 1264, however, has embraced New York's arbitration-based laws and included government-set parameters for payment amounts between health plans and providers. THA appreciates the environment of compromise surrounding this priority issue for consumers; however, there is a latent, negative impact to negotiated in-network rates between health plans and facilities. There is evidence that reference-based pricing in a similar New Jersey law to combat surprise billing resulted in a marked reduction in health plan reimbursement to hospitals. Hospitals serve as the safety nets for their communities, by, for example, providing lifesaving trauma care – often at a great expense. This care is an outlier to any benchmarking of reimbursement amounts. More, each year, hospitals write off or adjust millions of dollars of unpaid claims from patients and health plans through charity care and other policies, and data suggest that hospitals account for the minority of these billing practices. In fact, New York's anti-surprise billing legislation purposefully excluded hospitals, largely because they are overwhelmingly in-network with health plans and to avoid unintended negative consequences for hospitals.

Hospitals and hospital-based providers are paid differently and have their own contract arrangements with health plans. Texas hospitals are overwhelmingly in-network with health plans, with exceptions generally lasting for brief periods of time. Contracts with payors have grown increasingly complex. Texas hospitals want to preserve contracts that have already been negotiated with health plans, as well as a fair negotiation process between health plans and facilities.

THA respectfully offers the following suggestions to adjust SB 1264 to better fit hospitals, listed in order of preference. Texas hospitals feel strongly that mediation is the preferred option for facility negotiations. However, the following options related to arbitration are offered as an alternative only if mediation is unacceptable. These comments address the overall structure of the proposed legislation.

1. **Preserve the current mediation process for facilities but remove the consumer from the process as described in the first committee substitute to SB 1264.** The proposed arbitration process could

be maintained for facility-based providers, which THA understands is their preference. For hospitals, arbitration would create negative market disruptions to the detriment of patient access to care. Under arbitration, the arbitrator would consider the initial amount billed by the provider and the initial payment from the health plan and select one of these amounts as the final settlement. The arbitrator would be required to consider benchmark data – notably, the 50th percentile of rates paid by health plans and the 80th percentile of billed charges in the geographic area – to determine the most reasonable reimbursement rate. THA believes this process would drive reimbursement to the lowest amount. Most important, this could unravel negotiated contracts, particularly where a negotiated in-network rate with a health plan is higher than the plan's median rate. Health plans and facilities would not need to actually use the arbitration process to realize its impact – the very existence of the process, coupled with a low floor for reimbursement could prevent good faith negotiation between plans and facilities. This practice would incentivize the creation of narrow networks for the benefit of insurers and exclusion of hospitals that would be required to accept an out-of-network payment amount decided upon by a third-party arbitrator.

2. **For facilities, end the process at the informal settlement telephone conference described in Section 1467.051(h).** Under this scenario, the health plan and facility would be required to participate in the informal settlement conference or be deemed to accept the offer from the other party. Failure to reach an agreement would result in an appeal to the State Office of Administrative Hearings. The vast majority of claims under the current mediation process are resolved in a similar telephone conference. THA suggests preserving what works in the current law.

3. **Preserve the arbitration process for both facilities and providers but prohibit a health plan from offering an out-of-network rate that is less favorable than any contracted rate the health plan has ever had with that provider or facility.** Any reference to an external price needs to consider the agreements that have been carefully negotiated between health plans and facilities or providers. Including this protection in legislation would prevent bad faith negotiation practices and prevent a "race to the bottom." Hospitals are generally contracted with most or all health plans in their markets, and want to preserve these contracts, rather than revert to an out-of-network strategy. In addition, all references to the 50th percentile of rates paid to participating providers should be struck. A consideration of in-network rates that is applied to out of network providers is inappropriate and would only serve to unravel networks. If any reference points are used for hospitals, THA suggests creating a separate list of factors for the arbitrator to consider that are more relevant to facilities, such as trauma designation, length of stay, and other measures of quality. Any price reference point should be to publicly posted hospital charges already required by federal law, which would remove uncertainly.

4. **Preserve the arbitration process for facilities but exclude the references to prices described in Section 1467.0505(b) for facilities only.** Texas Hospitals believe they should be able to settle their own disputes with health plans based on any and all available data in the market. As long as health plans are held to a usual and customary rate on the front end, there should be no need for external

factors to govern the arbitration, particularly factors that could favor health plans and disadvantage hospitals.

THA hospitals have identified four other suggestions to improve the bill.

1. Section 1.01 of the bill allows the attorney general to bring a civil action to enjoin a facility-based provider or facility from balance billing and authorizes enforcement actions by licensing agencies. Although THA appreciates the intent of protecting consumers, this section is far too easy to unintentionally violate. Health plans, not providers, are in the best position to know whether an enrollee has met the enrollee's cost sharing obligations. THA suggests either removing this provision altogether or, in the alternative, requiring the health plan to assume responsibility for the enrollee's cost sharing obligations and collect any outstanding amounts owed directly from the enrollee. At the very least, there should be an intent requirement tied to any enforcement.

2. The bill should include provisions requiring health plans to provide better provider network participation information, as well as robust network adequacy protections. Consumers should be equipped with sufficient information to identify in-network providers, which will result in lower cost healthcare with predictable reimbursement. Broader networks will invariably lead to more consumer choices for in-network care. In addition, health plans should be held to a more timely and efficient credentialing process to onboard physicians and providers more quickly.

3. Section 2.07 requires facility-based providers and facilities to exhaust the health plan's internal dispute resolution process prior to requesting arbitration under the bill. There could be widespread variation in the appeals processes for health plans. THA's most significant concern with this provision is the inherent extension of time that follows it. This practice could result in a substantial delay in the adjudication of claims. The dispute resolution system adopted by this bill should govern the process.

4. THA has consistently expressed concern regarding a policy by certain health plans where a determination as to whether a patient's condition qualifies as an emergency is based on the patient's final diagnosis, rather than the patient's presenting symptoms. This runs contrary to accepted medical standards. More, under any version of this proposed legislation, consumers only benefit from the protections of the law if their treatment qualifies as emergency care. 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.

Respectfully submitted,

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Texas Hospital Association