Surprise Medical Billing in Texas

The Texas Way: Senate Bill 1264 (SB 1264 86R) by Senator Kelly Hancock and Representative Tom Oliverson protects patients in Texas from surprise medical bills.

Key Points of SB 1264

- Removes patients from the middle of provider and health plan payment disputes.
- Creates a mechanism for providers and health plans to submit to a third-party arbiter what they believe the payment for the service rendered should be, and the arbiter decides the payment.
- Applies to state health plans regulated by the Texas Department of Insurance (TDI), which include the Employees Retirement System (ERS) and the Teacher Retirement System (TRS). State regulated plans make up 20% of the market in Texas.

SB 1264 Results

- In 2020, TDI had 44,910 arbitration requests in the first year of implementation.
- In the preceding six months (Jan-Jun 2021), TDI had over 50,000 arbitration requests.
- From January 2020 to June 2022, TDI received 306,149 requests, of which 262,175 (86%) were eligible for arbitration.
- Surprise billing complaints to TDI from Texas patients and providers have significantly dropped since the passage of SB 1264.
- According to TDI data, on average, arbiters are awarding payment amounts closer to the original payment amount than the billed amount. However, we expect the billed amount and the original payment amount to slowly converge and reach a fair market value.
- SB 1264 also allows providers to include multiple claims, called bundling, on a single arbitration request, if the total amount in dispute is $5,000 or less and involves a single provider. From January 2020 to June 2022, 23% of arbitration requests involved bundled claims.[1]

The Federal Way: The ***No Surprises Act (NSA)*** is federal law that protects patients from surprise medical bills. As written, the law does not conflict with or negate the Texas arbitration process. However, the final rule issued by the U.S. Department of Health and Human Services (HHS), Department of Labor (DOL) and Department of the Treasury (USDT) directing implementation of the NSA strayed from congressional intent to unlawfully favor health plans. While several sections of the final rule violate the NSA, the most egregious deviation from the law as written is the de-facto rate benchmark set by the agencies in the rule, otherwise known as the qualifying payment amount (QPA).

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What is the QPA and why does it matter?

The Qualifying Payment Amount (QPA) is ***established by the health plans in a non-transparent process*** and represents the median in-network rate for a medical service in a defined geographic area. Physicians and medical groups are not given clear information on how it is determined or what it is ahead of time.

According to the NSA as written, the QPA should not be considered the most important benchmark. Instead, it is listed as ***one of many*** factors for arbiters to use when making a decision on what final payment should be. The rules created by HHS, DOL and USDT require the QPA be considered ahead of all other factors and suggest that arbiters choose the submitted amount closest to the QPA.

Defensive Action

The Texas Medical Association (TMA) was the first in the country to file suit against the federal agencies claiming the department's interim rules deviated from the congressional intent of the law. A federal judge ruled in TMA's favor, however, the agencies (HHS, DOL, USDT) released a final rule that still favors the QPA as the benchmark rate.

TMA has subsequently filed suit three more times and counting to address issues with the implementation of the NSA. Litigation is currently pending.

Stick to the Texas Way.

When health plans are permitted to de-facto rate set, they drive physicians out-of-network and pose a barrier to patient access to care.

This is Texas, we do not want the federal government or large health plans deciding who can access a physician and who can't.

The final rules tilted the scales in favor of the health plans. Despite the pending litigation, health plans continue to use the QPA to their advantage. Tilting the final payment toward QPA incentivizes the health plans to take action to lower their median in-network rates. This is exactly what is happening around the country; health plans are terminating contracts mid-term and offering physician groups take it or leave it—rate cuts on the order of 20-40%. Unable to take such low rates and pay staff and keep the lights on, the physician groups are driven out-of-network by insurers which decreases access to care and increases the number of claims requiring arbitration.

In Texas, we are fighting this practice by defending our state independent dispute resolution process and working to pass legislation to strengthen the health insurance network adequacy requirements in the state so the insurance plans cannot force medical groups out of network with their take it or leave it—offers.

1. *Balance Billing Biennial Report.* Texas Department of Insurance, Nov. 2022, www.tdi.texas.gov/reports/documents/SB1264-biennial-report-2022.pdf.