Allow Health Plans to Address Fraud

TAHP Opposes HB 1236 & SB 1139

TAHP
The Texas Association of Health Plans

What do the bills do? HB 1236 & SB 1139 change the prudent layperson standard to prohibit *any use* of a final emergency care diagnosis to identify potential fraud patterns. That doesn't align with federal law or policies of other states.

The basics: Under the "prudent layperson standard" a person gets to decide based on their own judgment if they are having a medical emergency. Essentially, **if you believe you need emergency care**, **that can't be questioned** and that goes for your insurance coverage as well.

Recent federal rules: In 2021, new rules clarified the prudent layperson standard, how it applies to emergency care coverage, and what rules health plans have to follow:

- **The rules further explain** that the plan or issuer must cover emergency services without limiting what constitutes an emergency medical condition **solely on the basis of diagnosis codes.** This is the big difference with HB 1236 as filed and how it can be fixed.

- **Bottom line**: This all means a health insurer is banned from denying a claim based on a final diagnosis, even if the insurer investigates the claim further after the denial.

Can a health insurer deny a claim based on the final diagnosis?

NO.

TAHP supports the federal prudent layperson standard

It protects patients and allows insurers to invesgigate fraud. HB strips away the investigave function and is inconsistent with federal law. TAHP opposes any change to the prudent layperson standard that prohibits health plans from holding providers accountable for fraud and abuse.

- HB 1236 & SB 1139 prohibit health insurers from investigating fraud based on a pattern of non-emergency final diagnosis codes, such as "upcoding" and other abuses.
- Federal law doesn't prevent this type of fraud protection and Texas is ground zero for fraudulent emergency care claims through freestanding ERs.
- Health plans today comply with federal and state prudent layperson laws and can still detect fraud. If a health plan sees a pattern of potential fraud they can investigate on a case-by-case basis, as required by federal law.

TEXAS ASSOCIATION OF HEALTH PLANS
Blake Hutson, bhutson@tahp.org, (512) 636-7213

February 2023

TAHP
The Texas Association of Health Plans

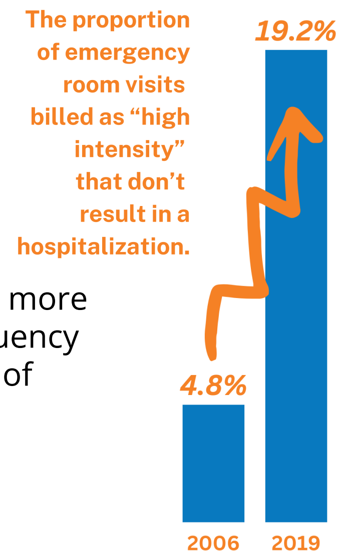
From 2012 to 2019:

- **Prices** rose 58%
- **Spending** rose 51%
- **Utilization** went down 4%

Source: Health Care Cost Institute, Ouch!: New Data reveals ER spending increased by 51% from 2012 – 2019, with patient out of pocket payments increasing by 85%, November 2021

What's "upcoding" and why does it matter? Upcoding is one type of billing abuse that happens when an emergency care staffing company falsely claims a higher severity code for a patient than what should apply.

- ER firms have a choice of 5 levels of severity to apply to a patient's bills. The highest severity codes should only be used for the most complicated patients and are reimbursed at significantly higher rates.
- A recent study found that the proportion of emergency room visits billed as "high intensity" that don't result in a hospitalization grew from 4.8% in 2006 to 19.2% in 2019.
- By 2021, level 4 was the most common level and accounted for more than one third (35%) of claims. Level 5 claims increased in frequency from 8% of emergency department claims in 2004 to a quarter of claims by 2021.
- A report in Tennessee found that one of the nation's largest ER staffing firms "has shelled out nearly $100 million to settle thousands of complaints from emergency room patients billed thousands of dollars for treatment of minor ailments, ranging from indigestion ($1,712) to a headache ($1,384)."



- Freestanding ERs routinely apply level 5 ER codes for simple, arguably even non-emergency care, like asymptomatic COVID-19 testing.

Fraud detection is critical in Medicaid and Medicare:

- **Texas Medicaid uses diagnosis codes** to stop this bad behavior and save taxpayer dollars for years. In, 2021, a "data led initiative" by the OIG resulted in nearly $20 million in fines for inappropriate ER billing.
- **Medicare ER fraud is also rampant:** In 2022, "all 11 defendants implicated in the $300 million Spectrum/Reliable healthcare fraud have pleaded guilty, announced U.S. Attorney for the Northern District of Texas.

TEXAS ASSOCIATION OF HEALTH PLANS
Blake Hutson, bhutson@tahp.org, (512) 636-7213

March 2023