Texas Association of Health Plans
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Dear Chairman Oliverson and Members of the House Insurance Committee,

A core function of health plans is to root out health care fraud and address the associated costs that affect all Texans. **The Texas Association of Health Plans (TAHP) opposes HB 1236 as filed, as it would hinder efforts to tackle emergency department fraud.** TAHP has been working with the bill author to ensure that patients are protected from coverage denials but are also still protected from ER billing fraud. We believe there is a way to address both of the concerns at the same time, but a solution must be applied both to hospital-based ERs as well as freestanding ERs.

HB 1236 seeks to modify the "prudent layperson standard" for emergency care health insurance coverage in Texas, ensuring that a health plan cannot deny coverage for ER care based on a final diagnosis. However, the bill's language extends beyond this intent, creating significant unintended consequences for combating emergency department fraud in Texas. **It is crucial to note that both current Texas law and federal law already prohibit a health plan from denying ER coverage based on a final diagnosis.**

TAHP strongly supports the existing prudent layperson standard in Texas and federal law, which mandates that a health plan must cover an emergency room visit if a "prudent layperson," possessing an average knowledge of medicine and health, believes their condition necessitates immediate medical care. This standard, already in place in Texas and federally, safeguards patients who reasonably believe their situation is an emergency, regardless of the final diagnosis. Furthermore, Texas' current "prudent layperson" standard has been adopted by nearly every state and was included in the Affordable Care Act's emergency care definition.

Recent federal rules for the "No Surprises Act" have also clarified that a health plan cannot deny an emergency claim based solely on the final diagnosis. This means that even if a patient's ultimate diagnosis is not emergency-related, the health care claims for the patient must be treated as emergency claims. However, the federal rules also clarified that health plans can continue to use diagnosis codes to hold hospital ERs and freestanding ERs accountable for fraud, waste, and abuse.

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HB 1236 alters this definition significantly, preventing health plans from using a final diagnosis in any capacity. This change would render Texas law inconsistent with federal law and other states' legislation, and more importantly, it would prohibit health plans from investigating and addressing patterns of fraud detected through final diagnoses. This bill essentially provides a free pass for hospital ER and freestanding ER fraud.

Why is this a problem?

Texas has a well documented history of fraudulent upcoding and other ER billing fraud in hospital ER and in freestanding ERs. Lawsuits, federal and state investigations, whistleblowers, and researchers uncovered rampant abuse that HB 1236 would effectively protect and reward.

The FBI lists upcoding as one of four common types of health care provider fraud. Upcoding 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, with level 5 being the most severe emergency and level 1 being the least severe. The highest severity codes should only be used for the most complicated patients and are reimbursed at significantly higher rates.

- **ER upcoding is now common** - In emergency departments, level 4 and 5 codes now make up the majority of claims. In the emergency department, the most common claim in 2004 was level 3. However, by 2021, level 4 was the most common and accounted for over one third (35%) of claims. Level 4 and 5 claims used to be 33% of all ER claims in 2004. This has grown to be 60% in 2021, a 71% increase in upcoding.
- 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."
- Freestanding ERs routinely apply level 5 ER codes for simple, arguably even non-emergency care. This includes examples like asymptomatic COVID-19 testing with charges as high as $54,000 for a single test.

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- The Center for Public Integrity discovered that "thousands of medical professionals have billed Medicare at progressively higher rates over a decade's time, costing taxpayers at least $11 billion in inflated charges."

Medicare and Medicaid programs have successfully identified fraud in ERs.

- Texas Medicaid uses diagnosis codes to stop fraudulent billing 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.
- 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.
- Tarrant County's John Peter Smith Hospital (JPS) has agreed to pay more than $3.3 million to settle allegations that it violated the False Claims Act by upcoding certain claims submitted to federal healthcare programs

For the commercial health care market—where payment rates to providers are significantly higher than in both Medicare and Medicaid— Texas health insurers must catch this fraud and abuse.

How to Address this Unintended Consequence

We have proposed changes to this issue that will ensure the purpose of the prudent layperson protections are preserved and enforced without undermining efforts to identify potential fraud.

TAHP requests that language be added to the bill to clarify that nothing in this bill prohibits health plans from considering diagnosis codes, in addition to all pertinent documentation and presenting symptoms, in emergency service determinations.

Concerns about Duplicative Appeals Processes

Additionally, the legislation as filed also creates an unnecessary new utilization review requirement for these personal health care decisions. Emergency care needs are not medical necessity determinations based on clinical decisions, but rather what a "prudent layperson" would think was an emergency. Utilization review is a very expensive and lengthy process and is related to the medical necessity of health care services not coverage determinations. It is not

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appropriate to use the UR process for coverage determinations. Federal rules already require separate internal and external appeal processes for coverage denials. As a result, the bill will create two separate overlapping and inconsistent appeals processes that slow down and restrict the claims review process so much that health plans will essentially be prohibited from reviewing emergency claims. TAHP recommends removing this provision.

We appreciate discussions with the author to remove this utilization review related provision as well as continued work to achieve the goal of the legislation while allowing health plans to address fraudulent ER billing.

Sincerely,

M. Blake Hutson

Blake Hutson
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