TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Written Comments Before the Ways and Means Committee
Access to Health Care in America: Ensuring Resilient Emergency Medical Care
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My name is Dr. Rick Snyder, and I am a cardiologist from Dallas and the president of the Texas Medical Association (TMA). On behalf of TMA, we thank Chairman Smith, Ranking Member Neal, and the Ways & Means Committee Members for the opportunity to provide written testimony in response to the field hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care.

TMA is a private, voluntary non-profit association of more than 57,000 Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. TMA's members practice in all medical specialties. Today, its vision is "Improving the health of all Texans."

TMA greatly appreciates today's discussion as access to physician-led care is central to furthering TMA's vision. To that end, we regularly advocate for bills directed at improving access to physician-led care at the state level, such as bills related to: (1) Texas' physician student loan repayment program; (2) the interstate medical licensure compact; (3) telemedicine payment parity; (4) graduate medical education funding; and (5) tort reform. All of these measures directly affect patient access to physician-led care (both inside and outside emergency department or facilities) in our state.

At the federal level, TMA has also advocated for the removal of the ban on the creation and expansion of physician-owned hospitals (POHs), which was enacted as Section 6001 of the Patient Protection and Affordable Care Act. We strongly contend that this provision inappropriately restricts patient access to care. It also limits job growth and competition. POHs exist in both rural and urban areas and include full-service general acute care and specialty hospitals. These entities can aid in boosting patient access to care and the quality of that care, as local physicians not only treat patients but also are heavily involved in making decisions about hospital operations, staff, equipment, training, and procedures that can best serve their patients and community. Thus, we urge the committee to re-evaluate this arbitrary ban.

In terms of emergency care specifically, TMA has also been a proponent of strengthening the prudent layperson standard that protects patients when health insurers review claims for emergency services. Without this protection, patients would be deterred from seeking medically necessary care in the emergency department as health plans could later deny coverage based upon the patient's failure to appropriately self-diagnose a complex medical condition (e.g., when a patient mistakes heartburn for a heart attack).

TMA has also been very engaged in legislative and regulatory advocacy related to "surprise" medical billing and network adequacy at both the state and federal level, as these two issues greatly impact patient access to care and coverage of care. In 2019, TMA supported Texas' surprise billing legislation as passed (i.e., Senate Bill 1264, 86th Texas Legislature, Regular Session), demonstrating our commitment to: (1) protecting the patients from surprise medical bills and (2) taking the patient out of the middle of these surprise billing disputes.

Notably, TMA also supported the patient protection intent of the federal No Surprises Act (NSA) when it was signed into law in December 2020. However, the implementation of the Texas and federal surprise billing laws has been very different. While Texas' surprise billing legislation (which is a "specified state law" under the NSA) has generally been viewed to be working in practice, TMA (much like physicians in Texas and throughout the nation) has been very concerned with the flawed implementation of the NSA and its detrimental impact on both patients and physicians.

My comments today will largely focus on issues surrounding the implementation of the NSA, as TMA has taken a leadership role in seeking redress for concerns regarding the rules implementing the NSA. Before delving into that, however, I first want to express our great appreciation for this committee's efforts to provide oversight over the flawed implementation of the NSA. It is critical that the Biden Administration implement the law as passed by Congress. We appreciate the committee recognizing this need and shining light on the concerns expressed by patients and physicians regarding the NSA's flawed implementation. As this committee knows, the NSA was bipartisan legislation that was carefully negotiated to protect patients and to establish a fair independent dispute resolution (IDR) process (i.e., one not skewed towards either health insurers or physicians and health care providers).

Unfortunately, the clear intent of the NSA has not been appropriately reflected in its implementing rules. Federal agencies have repeatedly adopted rules that flouted the plain language of the NSA and the Administrative Procedures Act (APA) and placed a thumb on the scale during IDR in favor of health insurers.

As a result, TMA has filed four lawsuits against these federal agencies, challenging various aspects of the NSA rules and/or guidance that: (1) conflicted with the law; (2) tilted scales in favor of insurers in the federal IDR process and (3) made IDR cost prohibitive for many physicians. TMA was successful in all four challenges at the district court level, obtaining orders that voided the unlawful rule provisions and/or guidance with nationwide effect. It is important to note that this series of lawsuits would have been unnecessary if the agencies had adopted rules that were consistent with both the letter and intent of the law.

To aid in understanding TMA's litigation related to NSA rulemaking, I offer a brief summary of our lawsuits below.

- TMA I and TMA II challenged agency rules regarding the weighting of the "qualifying payment amount" or "QPA" in the federal IDR process. Under the NSA, the QPA is supposed to be the median of the payor's contracted rates for the same or similar service furnished by a physician in the same or similar specialty and in the same geographic region, as calculated by the payor. Congress never intended to give the QPA privileged status in IDR determinations, as reflected in both the plain language of the law and the legislative history (wherein it was one of several factors to be considered in federal IDRs). Yet, in interim final rules challenged in TMA I, the federal agencies essentially rewrote the law by creating out of whole cloth a rebuttable presumption in favor of the QPA (thereby tilting IDR determinations in favor of health insurers). Notably, this language appeared nowhere in the NSA itself. When that rule language was struck down by the federal district court for the Eastern District of Texas, the agencies doubled down on this approach by adopting final rules that used different language but similarly privileged the QPA in IDR determinations. This prompted TMA's filing of its second lawsuit (i.e., TMA II).

- TMA III challenged four components of the QPA methodology under the federal agencies' rulemaking that conflicted with the law. More specifically, we successfully argued the federal rules permitted insurers to unlawfully deflate QPAs because they:
  ➢ include "ghost rates" in their QPA calculations – i.e., contract rates with physicians and others who don't actually provide the particular health service;
  ➢ allow insurers to include rates of physicians who are not in the same or similar specialty as the physicians in the payment dispute;
  ➢ require insurers to use an amount other than the total payment in calculating a QPA when a contracted rate includes contingent payments such as risk sharing or incentive-based bonuses; and
  ➢ permit self-insured plans to essentially opt in to a lower QPA for payment disputes with physicians by using the rates of other self-insured plans.

  TMA also challenged the lack of transparency surrounding the calculation of the QPA.

- In TMA IV we successfully challenged: (1) a 350% fee hike on the administrative fee for federal IDR and (2) batching rules that restricted IDR batching to the same service code (a limitation not imposed by the law), which creates a tremendous barrier to accessing the federal IDR process for medical specialties that have low dollar claims.

As of the date of these comments, TMA I is no longer an active case. The federal agencies did not move forward with their appeal of TMA's favorable district court decision in TMA I, as they

instead adopted final rules that became the focal point of TMA's second lawsuit (i.e., TMA II). After TMA successfully challenged components of the final rules in TMA II at the district court level, the federal agencies appealed that decision to the U.S. Court of Appeals for the Fifth Circuit. Oral arguments have been held in TMA II and a decision is pending.

TMA III is also on appeal at the U.S. Court of Appeals for the 5th Circuit. But it is important to note that the federal agencies have already abandoned their appeal of two of the four QPA methodology challenges, i.e., the same or similar specialty and self-insured plan rule. Thus, the agencies are only appealing the inclusion of ghost rates and the exclusion of bonus and incentive payments in the calculation of the QPA. Oral arguments have not yet been scheduled in TMA III.

Finally, in response to the favorable district court decision that TMA received in TMA IV, the federal agencies have issued new proposed rules related to administrative fees and batching. TMA submitted extensive comments in response to that rule proposal in January. While there were some improvements in the proposal, we continue to have concerns that the proposal did not go far enough to make the IDR process fair and accessible for physicians. We await the federal agencies' adoption of rules before assessing next steps.

TMA remains vigilant in monitoring the NSA rulemaking implementation, because each of the aforementioned rules dramatically impacts patients and physicians. TMA has stated repeatedly that unlawfully deflating the QPA and misrepresenting the QPA as reflecting the market in the IDR process would likely have a very detrimental impact on patient access to care and physician practice viability.

More specifically, outsized IDR consideration of a skewed QPA is likely to result in health plans exerting more pressure to lower in-network rates (effectively creating a race to the bottom) and health plan termination of long-standing physician contracts. This will compromise patient access to ***in-network*** care and is likely to lead to forced consolidation of physician practices to survive the payment cuts.

Physician practices in Texas and throughout the nation are already facing practice viability challenges in the aftermath of the COVID-19 pandemic. According to TMA's COVID-19 Practice Viability Survey of Texas Physicians, 63% of physician respondents reported their revenue had decreased 51% to 100% during the pandemic. Thus, before the adoption of some of the challenged rules, TMA raised patient access-to-care concerns, noting that that many small practices may simply be unable to keep their doors open under the added strain of unlawful rules that tilt the scales in favor of insurers. Nonetheless, the agencies moved forward with those rules, necessitating TMA's filing of litigation to address the agencies' overreach.

Furthermore, unlawful rules that make the IDR process cost-prohibitive threaten physician practice viability and therefore patient access to care, which is clearly counter to Congress' goal in passing the NSA.

TMA continues to hear concerns about other aspects of the NSA's implementation, including: (1) the challenges physicians are facing in terms of getting paid after a successful IDR decision; (2) concerns regarding a lack of transparency surrounding the QPA calculation; and (3) the need for QPA auditing. It is, therefore, critical that Congress continue to monitor the NSA's implementation in order to ensure that that the rules are promulgated consistent with the law and that these concerns are appropriately addressed. We very much appreciate the oversight work of the Ways & Means Committee. Once again, TMA thanks you for the opportunity to provide these comments.