Surprise Billing: State vs. Federal

TEXAS LAW and federal legislation both have systems to address payment disputes between physicians and health plans using independent dispute resolution (IDR). But they also have some key differences. Here's a look at some ways the state and federal laws compare.

TEXAS	FEDERAL
Plans covered Applies to state regulated PPO, EPO, and HMO plans, as well as Employee Retirement System/Teacher Retirement System plans. Also applies to health plans offered by certain nonprofit agricultural organizations.	**Plans covered** Applies to plans covered by the No Surprises Act that are not regulated by Texas' surprise billing laws (e.g., self-insured ERISA plans)
Services covered • Out-of-network emergency care and related supplies • Services and related supplies from an out-of-network, facility-based provider at an in-network facility • Services and related supplies provided by out-of-network diagnostic imaging or laboratory services provider, if performed in connection with a health care service performed in-network	**Services covered** • Emergency services by an out-of-network provider or out-of-network emergency facility • Non-emergency services by an out-of-network provider at an in-network health care facility • Out-of-network air ambulance provider services
Initial payment Usual and customary rate or an agreed-to rate	**Initial payment** Determined by health plan
Time to initiate IDR Between 21 and 90 days after receiving initial payment	**Time to initiate IDR** If not satisfied with initial payment, the physician may enter into a 30-business-day open negotiation period with the plan. If no agreement reached during that period, four days to declare initiation of IDR.
IDR decisionmaker/arbitrator Thirty days for parties to select arbitrator by mutual agreement; after that, the Texas Department of Insurance selects one.	**IDR decisionmaker/arbitrator** Physician and plan jointly select decisionmaker within three business days after initiation of IDR.
Factors considered in IDR (partial list) • Level of training, education, and experience of the out-of-network physician • Physician's usual billed charge for comparable services or supplies to other patients when the physician is out-of-network • Circumstances and complexity of the patient's case • The history of network contracting between the two sides • 80th percentile of all billed charges for the service/supply performed by physicians in the same or similar specialty and in the same geozip area • 50th percentile of rates for the service/supply paid to network-participating physicians in the same or similar specialty and in the same geographic area	**Factors considered in IDR (partial list)** • "Qualifying payment amount" (QPA) for the same service in the same geographic region* • Offers by both parties • Circumstances of the case, which include: training, experience, quality, and outcomes measurements; and case complexity *The part II interim final rules created a rebuttable presumption that the QPA is the appropriate out-of-network rate. TMA has a pending lawsuit challenging the QPA rebuttable presumption. For more information on the lawsuit, visit www.texmed.org/Surprise.
Payment amounts Either the billed charge or the payment made by the health plan. Amounts may be modified during previous appeal process or during informal settlement teleconference.	**Payment amounts** Either the physician's offer or the plan's