

1 The Reference Committee on Socioeconomics, having met on Friday, May 18, 2018, with all members
 2 present, submits the following report:

- 3
 4 (1) President’s Report 1 – Physician-Led Initiatives to Address Maternal Mortality and Morbidity

5
 6 RECOMMENDATION:

7
 8 Madam Speaker, your reference committee recommends that the recommendations in President’s
 9 Report 1 be adopted.

10
 11 This report recommends that TMA:

- 12
 13 (1) Pursue legislation authorizing the Texas Health and Human Services Commission to: (a) submit
 14 a federal Medicaid 1115 demonstration waiver requesting approval to design and implement a
 15 tailored health benefits program for eligible uninsured women of childbearing age that provides
 16 12 months’ continuous coverage for preventive, primary, and specialty care coverage, including
 17 behavioral health services, to women before, during and after pregnancy; (b) ensure adolescents
 18 aging out of the Children’s Health Insurance Program (CHIP) are seamlessly enrolled into
 19 Healthy Texas Women; (c) ensure women losing CHIP-Perinatal are seamlessly connected to
 20 the Family Planning Program to avoid gaps in preventive health care; and (d) implement
 21 initiatives that improve early-entry prenatal care, including a statewide campaign on the
 22 importance of prenatal care during the first trimester, expediting Medicaid eligibility and
 23 enrollment for pregnant women, promoting use of telemedicine for routine prenatal care, and
 24 reforming the Medicaid transportation program to ensure pregnant women with young children
 25 can travel with their children to obtain preventive services.
 26
 27 (2) Develop a continuing medical education program for physicians that covers: (1) information on
 28 publicly funded support services for women with substance use disorders (SUDs); (2)
 29 guidelines for the prescribing of opioids and pain management; (3) efforts to better connect
 30 SUD treatment physicians and providers with women’s health physicians and providers to
 31 ensure women undergoing treatment for these disorders are able to obtain preventive health
 32 care services, and (4) diagnosis and treatment of behavioral health issues such as anxiety and
 33 depression.
 34
 35 (3) Develop legislation to: (1) allocate sufficient state resources to resolve red tape and payment
 36 barriers preventing widespread adoption of long-acting reversible contraceptives (LARCs),
 37 including ensuring the state pays physicians, hospitals, and clinics their full LARC acquisition
 38 costs so women can obtain a LARC according to clinical best practice; (2) ensure availability of
 39 LARCs immediately following delivery to women enrolled in the Children’s Health Insurance
 40 Program (CHIP)-Perinatal; and (3) remove roadblocks preventing teens from simultaneously
 41 enrolling in CHIP and Healthy Texas Women to obtain contraceptive services with parental
 42 consent.
 43
 44 (4) Develop a continuing medical education program, in partnership with the American College of
 45 Obstetricians and Gynecologists District XI (Texas Chapter), Texas Association of
 46 Obstetricians and Gynecologists, and Texas Academy of Family Physicians, designed to
 47 increase patients’ and physicians’ awareness of long-acting reversible contraceptives as the
 48 most effective form of contraception.
 49

1 (5) Develop continuing medical education programs on: (1) quality-based initiatives with
2 standardized protocols and best practices to improve prenatal, labor and delivery and
3 postpartum health outcomes; and (2) implementation of hospital-based quality improvement
4 initiatives that reduce maternal mortality and morbidity, based on best practice and
5 standardized protocols.
6

7 (6) Introduce legislation to improve the quality of health data records for women of reproductive
8 age to support patient health, the quality of maternal death records, and the exchange of health
9 information for women of reproductive age. The legislation should encompass: (a) support of
10 comprehensive efforts to improve the state's surveillance of maternal mortality and ensuring
11 Texas' maternal death records have accurate information on the factors associated with
12 maternal deaths; (b) mandates to the Texas Department of State Health Services to develop
13 training and educational materials for physicians and other medical certifiers to accurately
14 report maternal deaths; and (c) mandates to electronic health record systems to improve the
15 interoperability of health records, including resolution of barriers that are preventing the
16 exchange of health information critical to providing quality maternal and postpartum care.
17

18 (7) Develop a public campaign to increase awareness of the importance of early and timely
19 maternal health care and promote existing community based efforts.
20

21 Your reference committee heard overwhelming testimony in support of the report.
22

23 (2) Council on Health Service Organizations Report 1 – Policy Review
24

25 RECOMMENDATION:
26

27 Madam Speaker, your reference committee recommends that the recommendations in Council on
28 Health Service Organizations Report 1 be adopted.
29

30 This report recommends that: (1) Policies 65.006, 115.008, 130.014, and 130.015 be retained, and
31 (2) Policies 85.015, 125.005, and 125.006 be retained as amended.
32

33 Your reference committee heard testimony in support of the report.
34

35 (3) Council on Health Service Organizations Report 2 – Medical Staff Rights and Responsibilities Bill
36 of Rights
37

38 RECOMMENDATION:
39

40 Madam Speaker, your reference committee recommends that the recommendation in Council on
41 Health Service Organizations Report 2 be adopted.
42

43 This report recommends that the following be adopted as TMA policy on medical staff rights and
44 responsibilities:
45

46 TMA recognizes the following fundamental responsibilities of the medical staff:
47

- 48 • The responsibility to provide for the delivery of high-quality and safe patient care, the provision
49 of which relies on mutual accountability and interdependence with the hospital's governing
50 body;

- 1 • The responsibility to provide leadership and work collaboratively with the hospital's
- 2 administration and governing body to continuously improve patient care and outcomes;
- 3 • The responsibility to participate in the hospital's operational and strategic planning to safeguard
- 4 the interest of patients, the community, the hospital, and the medical staff and its members;
- 5 • The responsibility to establish qualifications for membership and fairly evaluate all members
- 6 and candidates without the use of economic criteria unrelated to quality, and to identify and
- 7 manage potential conflicts that could result in unfair evaluation;
- 8 • The responsibility to establish standards and hold members individually and collectively
- 9 accountable for quality, safety, and professional conduct; and
- 10 • The responsibility to make appropriate recommendations to the hospital's governing body
- 11 regarding membership, privileging, patient care, and peer review.

12
13 TMA recognizes that the following fundamental rights of the medical staff are essential to the
14 medical staff's ability to fulfill its responsibilities:

- 15
- 16 • The right to be self-governed, which includes but is not limited to (1) initiating, developing, and
- 17 approving or disapproving of medical staff bylaws, rules, and regulations; (2) selecting and
- 18 removing medical staff leaders; (3) controlling the use of medical staff funds; (4) being advised
- 19 by independent legal counsel; and (5) establishing and defining, in accordance with applicable
- 20 law, medical staff membership categories, including categories for nonphysician members;
- 21 • The right to advocate for its members and their patients without fear of retaliation by the
- 22 hospital's administration or governing body;
- 23 • The right to be provided with the resources necessary to continuously improve patient care and
- 24 outcomes;
- 25 • The right to be well informed and share in the decision making of the hospital's operational and
- 26 strategic planning, including involvement in decisions to grant exclusive contracts or close
- 27 medical staff departments;
- 28 • The right to be represented and heard, regardless of the voting rights of the physician as
- 29 outlined by the medical staff bylaws, at all meetings of the hospital's governing body; and
- 30 • The right to engage the hospital's administration and governing body on professional matters
- 31 involving their own interests.

32
33 TMA recognizes the following fundamental responsibilities of individual medical staff members,
34 regardless of contractual or independent status:

- 35
- 36 • The responsibility to work collaboratively with other members and with the hospital's
- 37 administration to improve quality and safety;
- 38 • The responsibility to provide patient care that meets the professional standards established by
- 39 the medical staff;
- 40 • The responsibility to conduct all professional activities in accordance with the bylaws, rules,
- 41 and regulations of the medical staff;
- 42 • The responsibility to advocate for the best interest of patients, even when such interest may
- 43 conflict with the interests of other members, the medical staff, or the hospital;
- 44 • The responsibility to participate and encourage others to play an active role in the governance
- 45 and other activities of the medical staff;
- 46 • The responsibility to participate in peer review activities, including submitting to review,
- 47 contributing as a reviewer, and supporting member improvement.
- 48

1 TMA recognizes that the following fundamental rights apply to individual medical staff members,
2 regardless of contractual or independent status, and are essential to each member's ability to fulfill
3 the responsibilities owed to his or her patients, the medical staff, and the hospital:
4

- 5 • The right to exercise fully the prerogatives of medical staff membership afforded by the
6 medical staff bylaws, which right may not be waived as a condition of employment or medical
7 staff privileges;
- 8 • The right to make treatment decisions, including referrals, based on the best interest of the
9 patient, subject only to review by peers;
- 10 • The right to exercise personal and professional judgment in voting, speaking, and advocating
11 on any matter regarding patient care or medical staff matters, without fear of retaliation by the
12 medical staff or the hospital's administration or governing body;
- 13 • The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are
14 actively practicing physicians in the community and in the same specialty;
- 15 • The right to full due process before the medical staff or hospital takes adverse action affecting
16 membership or privileges, including any attempt to abridge membership or privileges through
17 the granting of exclusive contracts or closing of medical staff departments;
- 18 • The right to immunity from civil damages, injunctive or equitable relief, and criminal liability
19 when participating in good faith peer review activities; and
- 20 • The right to be free of "sham peer reviews" and manipulation of medical staff bylaws by
21 hospitals attempting to silence or inhibit the voicing of physician concerns regarding the
22 advocacy of their patients
23

24 Your reference committee heard testimony in support of the report.

- 25 (4) Council on Health Service Organizations Report 3 – Due Process Rights in Physician Contracts
26 with Hospitals
27

28 RECOMMENDATION:
29

30 Madam Speaker, your reference committee recommends that the recommendations in Council on
31 Health Service Organizations Report 3 be adopted.
32

33 This report recommends:
34

- 35 (1) That TMA advocate for the Centers for Medicare & Medicaid Services' strengthening of the
36 due process rights of physicians by revising Medicare's Conditions of Participation for
37 hospitals to guarantee that physicians be entitled to fair hearings by peers before any
38 termination or restriction of medical staff privileges and that those due process rights cannot be
39 denied through a third-party contract.
40

- 41 (2) That Policy 185.020, Principles for Employment Contracts, be amended.
42

43 Your reference committee heard testimony in favor of the report.
44

- 45 (5) Council on Socioeconomics Report 1 – Policy Review
46

47 RECOMMENDATION:
48

49 Madam Speaker, your reference committee recommends that the recommendations in Council on
50 Socioeconomics Report 1 be adopted.

1 This report recommends that: (1) Policies 65.007, 65.008, 110.008, 115.009, 115.013, 145.009,
2 145.010, 180.008, 180.024, 190.027, 190.028, 195.028, 235.028, 245.015, and 260.052 be retained;
3 (2) Policies 55.029, 65.011, 80.003, 190.017, 230.005, 265.017, 320.007, and 335.007 be retained
4 as amended; and (3) Policies 105.015 and 190.026 be deleted.
5

6 Your reference committee heard testimony in favor of the report. There was testimony on behalf of
7 the Council on Medical Education asking for substantial changes to policy 320.007. In response to
8 the suggested changes, the chair of the Council on Socioeconomics testified that the Council could
9 not support the changes because the full council had not been offered the opportunity to review
10 them. The reference committee agreed that the changes were substantial and should first be
11 reviewed by the Council on Socioeconomics.
12

13 (6) Council on Socioeconomics Report 2 – Geographic Practice Cost Indices Policy
14

15 RECOMMENDATION:
16

17 Madam Speaker, your reference committee recommends that the recommendation in Council on
18 Socioeconomics Report 2 be adopted.
19

20 This report recommends that Policy 240.014 be retained as amended.
21

22 Your reference committee heard testimony only in support of the report.
23

24 (7) Council on Socioeconomics Report 3 – Transparency and Payments for Prior Authorizations
25 (Resolution 406-A-17)
26

27 RECOMMENDATION:
28

29 Madam Speaker, your reference committee recommends that the recommendations in Council on
30 Socioeconomics Report 3 be adopted.
31

32 This report recommends that: (1) TMA policy 235.0354 be amended; (2) TMA adopt policy on
33 standardize electronic prior authorization recommendations; and (3) that the Council on
34 Socioeconomics Report 3-A-18 be adopted in lieu of Resolution 406-A-17.
35

36 Your reference committee heard testimony in support of the report.
37

38 (8) Council on Socioeconomics Report 4 – Compensation of Physicians for Authorizations and
39 Preauthorizations (Resolution 408-A-17)
40

41 RECOMMENDATION:
42

43 Madam Speaker, your reference committee recommends that the recommendation in Council on
44 Socioeconomics Report 4 be adopted.
45

46 This report recommends that Resolution 408-A-17 not be adopted.
47

48 Your reference committee heard testimony in favor of the report.
49

- 1 (9) Council on Socioeconomics Report 5 – Clearer Language Regarding the Physician’s Role in
2 Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution
3 411-A-17)
4

5 RECOMMENDATION:
6

7 Madam Speaker, your reference committee recommends that the recommendation in Council on
8 Socioeconomics Report 5 be adopted.
9

10 This report recommends that Resolution 411-A-17 not be adopted.
11

12 Your reference committee heard testimony applauding the hard work done by the MSS on this
13 important topic. Testimony also pointed out that existing TMA policy supports the intent of the
14 resolution.
15

- 16 (10) Council on Socioeconomics Report 6 – Medicaid Work Requirements
17

18 RECOMMENDATION:
19

20 Madam Speaker, your reference committee recommends that the recommendations in Council on
21 Socioeconomics Report 6 be adopted.
22

23 This report recommends that TMA oppose:
24

25 (1) Any federal Medicaid waiver seeking to impose mandatory work requirements, but instead
26 collaborate with lawmakers, the Texas Health and Human Services Commission, and the Centers
27 for Medicare & Medicaid Services to support constructive measures to help Medicaid enrolled and
28 eligible patients overcome barriers that prevent them from working or engaging in other meaningful
29 community activities.
30

31 (2) Efforts to impose lifetime limits on adult Medicaid enrollees.
32

33 (3) Any policy or regulation that punitively limits access to affordable health care for Medicaid-
34 eligible patients.
35

36 Your reference committee heard overwhelming testimony in favor of the report.
37

- 38 (11) Committee on Emergency Medical Services and Trauma Report 2 – Policy Review
39

40 RECOMMENDATION:
41

42 Madam Speaker, your reference committee recommends that the recommendations in Committee
43 on Emergency Medical Services and Trauma’s Report 2 be adopted.
44

45 This report recommends:
46

47 (1) Policies 100.022, 100.023, 100.025, and 100.026 be retained; (2) Policy 100.024 be retained as
48 amended; and (3) Policy 100.021 be deleted.
49

50 Your reference committee heard testimony in support of the report.
51

1 (12) Committee on Medical Home and Primary Care Report 2 – Policy Review

2
3 RECOMMENDATION:

4
5 Madam Speaker, your reference committee recommends that the recommendation in Committee on
6 Medical Home and Primary Care Report 2 be adopted.

7
8 This report recommends Policy 255.004 be retained.

9
10 Your reference committee heard testimony in favor of the report.

11
12 (13) Resolution 401 – Physicians Allowed to Delegate Ability to Enter EHR Data (McLennan County
13 Medical Society)

14
15 RECOMMENDATION A:

16
17 Madam Speaker, your reference committee recommends that Resolution 401 be amended by
18 addition and deletion as follows:

19
20 This resolution resolves that TMA:

21
22 (1) Supports the physician’s ability of the physician to delegate the collection and data entry into
23 any part of the physician’s notes in the medical electronic health record (EHR), any component of
24 including the chief complaint and medical history of present illness sections, that they deem
25 appropriate, provided that the physician reviews the information with the patient and takes
26 responsibility for the full medical record being created and used to support billing

27
28 (2) ~~Ask Novitas Solutions to reverse it (erroneous) interpretation — mandating that physicians~~
29 ~~personally enter data into the physician notes of an EHR — of the Centers for Medicare & Medicaid~~
30 ~~Services (CMS) to communicate this policy given that to other Medicare administrative contractors,~~
31 ~~have not made such restrictions and CMS does not make such restrictions concerning the chief~~
32 ~~complaint and history of present illness sections of the EHR, and~~

33
34 (3) ~~Endorse the policy of physicians hiring appropriately trained assistants such as scribes, nurses,~~
35 ~~health information transcriptionists to enter data into any and all portions of the medical record the~~
36 ~~physician deems appropriate.~~

37
38 All testimony favored the intent of the resolution however the author as well as other TMA councils
39 and committees suggested that the resolution be amended for clarity. The reference committee
40 agreed with the author that the third resolved should be deleted because there were concerns about
41 the definition of “appropriately trained assistants”.

42
43 RECOMMENDATION B:

44
45 Madam Speaker, your reference committee recommends that Resolution 401 be adopted as
46 amended.

47

- 1 (14) Resolution 402 – Opposition to Medicaid Work Requirements (Ryan Van Ramshorst, MD, Texas
2 Pediatric Society)

3
4 RECOMMENDATION:

5 Madam Speaker, your reference committee recommends that Resolution 402 be adopted.

6
7 This resolution resolves that TMA apply all appropriate resources to oppose Medicaid work
8 requirements to ensure that vulnerable, low-income adults with children and other covered
9 populations continue to receive necessary medical services and that Texas does not increase
10 uncompensated care for physicians.

11
12 Your reference committee heard overwhelming testimony in support of the report.

- 13
14 (15) Resolution 403 – Under-Reporting of Optometric Diabetic Eye Examinations to Treating
15 Physicians (Harris County Medical Society)

16
17 RECOMMENDATION A:

18
19 Madam Speaker, your reference committee recommends that Resolution 403 be amended by
20 addition and deletion as follows:

21
22 This resolution resolves that TMA:

23
24 (1) ~~TMA establish better affiliations~~ Work with the Texas Optometry Board to develop ~~rules~~
25 guidelines around conditions that need to be reported to the patient's physician, ~~and~~

26
27 ~~(2) this resolutions be forwarded to the American Medical Association for similar action.~~

28
29 Your reference committee heard testimony acknowledging that this topic is of concern to
30 physicians. The author of the resolution acknowledged that further clarification was needed before
31 forwarding a resolution to the AMA.

32
33 RECOMMENDATION B:

34
35 Madam Speaker, you reference committee recommends that Resolution 403 be adopted as
36 amended.

- 37
38 (16) Resolution 404 – Opposition of Pain Score as a Contributor to Hospital Financial Incentives
39 (Medical Student Section)

40
41 RECOMMENDATION:

42
43 Madam Speaker, your reference committee recommends that Resolution 404 be adopted.

44
45 This resolution resolves that TMA oppose the allocation of financial incentives for high patient
46 satisfaction scores that weigh patient-rated treatment of pain against other factors involved in
47 patient care.

48
49 Your reference committee heard testimony in support of the resolution.

- 1 (17) Resolution 405 – Compensation to Physicians for Authorizations and Preauthorizations (Ori Z.
2 Hampel, MD)

3
4 RECOMMENDATION:

5
6 Madam Speaker, your reference committee recommends that Resolution 405 be referred.

7
8 This resolution resolves that insurance and managed care companies (“payers”) compensate
9 physicians for the time that physicians and their staff spend on authorization and preauthorization
10 procedures. Such compensation shall be paid in full by payers to physicians without deductible,
11 coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such
12 processes imposed by payers. The fee schedule shall be based on the compensation due-physicians
13 for patient evaluation and management according to the Current Procedural Terminology (CPT)
14 coding system. For physicians contracted with payers, the payers shall compensate the physician at
15 the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians
16 at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per
17 patient per day performing tasks related to authorization and preauthorization, and round the time
18 spent per task up to the nearest five-minute increment. The physician shall bill the payer in
19 accordance with the CPT coding system based on the time spent. If necessary, multiple codes shall
20 be used and payable to account for the time spent. Billable minutes for authorization and
21 preauthorization include, but are not limited to, time spent filling out forms, making telephone calls
22 (including time spent negotiating phone trees and hold time), documenting in the patient’s medical
23 record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to
24 payment timeliness by third-party payers shall apply to payers for such billing as well.

25
26 Your reference committee heard testimony regarding the ongoing frustration physicians are
27 experiencing with the complex, burdensome and overwhelming authorization and preauthorization
28 procedures they must comply with in order to provide timely and necessary care to their patients.
29 The author of the resolution offered a friendly amendment to the original resolution as was
30 submitted in the HOD handbook. Changes were made after review and discussion with TMA
31 General Counsel as the language in the original resolution could create anti-trust implications. The
32 author submitted the following language as a friendly amendment to the original resolution:

33
34 That insurance companies and managed care companies, including companies managing
35 governmental insurance plans, (“payers”) compensate physicians for the time that
36 physicians and their staff spend on authorization and preauthorization procedures (“tasks”).
37 Such compensation shall be paid in full by payers to physicians without deductible,
38 coinsurance, or copayment billable to patients; thus, patients will not bear the burden for
39 such processes imposed by payers. Physicians shall bill payers for time spent by physicians
40 and their staff in performing such tasks at a rate commensurate with that of the most highly
41 trained professionals. Such a rate should increase from time to time to keep up with the
42 Consumer Price Index. Payers shall pay physicians promptly upon receiving such a bill
43 with significant interest penalties assessed for delay in payment. Billable minutes for
44 authorization and preauthorization include, but are not limited to, time spent filling out
45 forms, making telephone calls (including time spent negotiating phone trees and hold time),
46 documenting in the patient’s medical record, communicating with the patient, altering
47 treatment plans (such as changing medications to comply with formularies), printing,
48 copying, and faxing.

49
50 There was no testimony opposing the friendly amendment as it did not change the overall spirit of
51 the resolution, which is that physicians should be compensated for the excessive amount of time

1 and burden the health plans create with their authorization and preauthorization requirements. There
2 was testimony in support of referral. Those in support of referral felt that while the issue of
3 payment for prior authorization is an ongoing burden for physicians, further study is needed. The
4 reference committee believes that referral would be the best way to address the issue.

- 5
6 (18) Resolution 406 – Supporting Reclassification of Complex Rehabilitation Technology (Resident and
7 Fellow Section)

8
9 RECOMMENDATION A:

10
11 Madam Speaker, your reference committee recommends that Resolution 406 be amended by
12 addition of a second resolve to read as follows:

- 13
14 (1) TMA support the Centers for Medicare & Medicaid Services reclassifying complex
15 rehabilitation technology equipment into its own distinct payment category under the Medicare
16 program to improve access to individuals with substantially disabling and chronic conditions.
17
18 (2) The Texas delegation to the American Medical Association should take a similar resolution to
19 the AMA.

20
21 Your reference committee heard testimony in support of the resolution. There was testimony about
22 the importance of this topic also being addressed by the AMA. The author of the resolution
23 supported the recommendation to ask the Texas Delegation to take a similar resolution to the AMA.
24 The reference committee also supported this recommendation.

25
26 RECOMMENDATION B:

27
28 Madam Speaker, you reference committee recommends that Resolution 406 be adopted as
29 amended.

- 30
31 (19) Resolution 407 – Medical Necessity Decisions Are the Practice of Medicine (Harris County
32 Medical Society)

33
34 RECOMMENDATION:

35
36 Madam Speaker, your reference committee recommends that the recommendations in Resolution
37 407 be adopted.

38
39 This resolution resolves that TMA work to:

- 40
41 (1) Align the Texas Occupation Code, Texas Insurance Code, and Texas Administrative Code with
42 clear verbiage that medical necessity decisions are the practice of medicine and can only be
43 performed by a physician with an active license in the state of Texas and
44
45 (2) Align the Texas Occupations Code, Texas Insurance Code, and Texas Administrative Code with
46 clear verbiage requiring that those making peer-to-peer medical necessity decisions be in the same
47 or similar specialty as the treating physician seeking authorization.

48
49 Your reference committee heard testimony in support of the resolution.
50

- 1 (20) Resolution 408 – Protecting the Prudent Layperson Standard (Carrie de Moor, MD, Collin-Fannin
2 Medical Society, Nueces County Medical Society, and Heidi Knowles, MD, Texas College of
3 Emergency Physicians)

4
5 RECOMMENDATION A:

6
7 Madam Speaker, your reference committee recommends that Resolution 408 be amended by
8 addition and deletion as follows:

9
10 This resolution resolves that TMA:

- 11
12 (1) Adopt the following principles related to ~~unanticipated, unscheduled~~ out-of-network emergency
13 care:

14
15 ~~**Unanticipated, Unscheduled Out-of-Network Care:**~~ Patients who seek emergency care
16 should be protected under the “prudent layperson” standard as established in state and
17 federal law, without regard to prior authorization or retrospective denial for services after
18 emergency care is rendered.

19
20 Patients must not be financially penalized for receiving ~~unanticipated, unscheduled~~
21 emergency care from an out-of-network physician or provider.

22
23 Insurers must meet appropriate network adequacy standards that include adequate patient
24 access to care, including access to physician specialties. Texas Department of Insurance
25 should enforce such standards through active regulation of health insurance company plans.

26
27 Insurers must be transparent and proactive in informing enrollees about all deductibles,
28 copayments, and other out-of-pocket costs that enrollees may incur.

29
30 ~~Out-of-network payments must not be based on a contrived percentage of the Medicare rate~~
31 ~~or rates determined by the insurance company.~~

32
33 ~~Minimum coverage standards for unanticipated out-of-network services should be~~
34 ~~identified. Minimum coverage standard should pay out-of-network physicians and~~
35 ~~providers at the usual and customary out-of-network charges for services, with the~~
36 ~~definition of usual and customary based upon a percentile of all out-of-network charges for~~
37 ~~the particular health care service performed by a physician or provider in the same or~~
38 ~~similar specialty and provided in the same geographical area as reported by a benchmarking~~
39 ~~database. Such a benchmarking database must be independently recognized and verifiable,~~
40 ~~completely transparent, independent of the control of either payers or physicians and~~
41 ~~providers and maintained by a nonprofit organization. The nonprofit organization shall not~~
42 ~~be affiliated with an insurer, a municipal cooperative health benefit plan, or health~~
43 ~~management organization.~~

44
45 Medical necessity review of emergency services must be performed by a board-certified
46 emergency medicine physician licensed in Texas and not affiliated with an insurer, a
47 municipal cooperative health benefit plan, health management organization, or the
48 physician or provider or facility in question.

49
50 ~~Health plans should readily disclose their pricing methodologies for payment for both in-~~
51 ~~network and out-of-network emergency care to health plan members, employers,~~

