May 8, 2018

Kent Sullivan, Commissioner
Texas Department of Insurance
333 Guadalupe St.
Austin, TX 78701

Dear Commissioner Sullivan:

Under Texas law, are health maintenance organizations allowed to punish patients who seek care for what they legitimately believe is a medical emergency?

On behalf of the member physicians, medical student, and administrators of the undersigned Texas medical societies, we are writing to ask you to provide an update on the Texas Department of Insurance's review/assessment of the upcoming Blue Cross and Blue Shield of Texas (BCBSTX) policy on management of emergency benefits for subscribers to certain of its HMO plans.

In an April 18 memo to its producers and salespeople (attached), BCBSTX announced that its fully insured group and retail HMO members may be responsible for their entire bill if they go to an out-of-network emergency department "as a convenience for a condition they don't think is serious or life-threatening." The change will take effect with claims incurred after June 4.

We do not believe patients should be expected to self-diagnose to determine whether their symptoms are serious enough to warrant an emergency department visit. But with this policy, BCBSTX is asking that patients act as highly trained diagnosticians, skills our members spent many years of their lives acquiring. BCBSTX is asking them to diagnose their symptoms at a critical and emotional moment, when time could be of the essence. As a result, it is very likely that extremely ill patients will not seek needed emergency medical care while, bluntly, their conditions worsen or they die.

As you know, Texas law (i.e., Texas Insurance Code §§843.002(7) and 1271.155) uses the "prudent layperson" standard for emergency care coverage by HMOs:

> (7) "Emergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:
>
> (A) place the individual's health in serious jeopardy;
> (B) result in serious impairment to bodily functions;
> (C) result in serious dysfunction of a bodily organ or part;

(D) result in serious disfigurement; or
(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.

Federal law[1] and numerous other states' laws rely on a similarly worded standard.

For example, when a person wonders if his or her chest pain is indigestion or a heart attack, will HMOs now be allowed now to penalize that person if he or she seeks care only to learn the ailment is the lesser concern? Or whether head trauma caused a concussion? Or whether abdominal pain is constipation or actually a dangerous appendicitis?

To expand, we respectfully and specifically point you to an example BCBSTX cites in the attached memo. "Some of our members are using the emergency room for things like … sprained ankles, for convenience rather than for serious or life-threatening issues."

Mild or moderate ankle sprains can be treated simply with rest, ice, and at-home exercise. Some ankle injuries that present with similar symptoms, however, require immediate care. It is not reasonable for an HMO to expect that a "prudent layperson possessing an average knowledge of medicine and health," in significant pain, can differentiate between a sprain, a fractured bone in the ankle, and a dislocated ankle.

Clearly, the purpose of the "prudent layperson" standard in the Texas HMO Act is to shield patients from having to make such specific self-diagnoses, and to encourage them to seek emergency care appropriately without having to have medical expertise or a detailed understanding of the law. Scaring them into avoiding emergency care seems a heavy-handed approach that could be detrimental to good patient care.

A more appropriate direction would be for BCBSTX to educate its enrollees on more appropriate in-network venues available, ranging from medical homes to urgent care centers to emergency centers.

We strongly encourage you to evaluate BCBSTX's new policy against this standard and the other relevant provisions of the Texas HMO Act. Feel free to contact Darren Whitehurst of the Texas Medical Association staff at (512) 370-1350 if we can be of assistance.

Sincerely,

Carlos J. Cardenas, MD
President
Texas Medical Association

Gerad Troutman, MD, FACEP
President
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[1] 29 C.F.R. §2590.715-2719A(b); 29 C.F.R. §2590.715-2719A(b)(4)(i).

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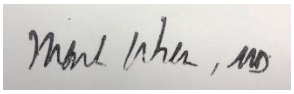

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Attachment

BlueCross BlueShield of Texas

April 18, 2018

Learn More About Our HMO Emergency Benefit Management Process

Some of our members are using the emergency room (ER) for things like head lice or sprained ankles, for convenience rather than for serious or life-threatening issues. Doing so not only drives up costs for our members, but uses limited ER resources for conditions that are not serious or life threatening. We want to make health care affordable for our members, and to do so, we have to be good stewards of their money.

What You Need to Know:

- Starting June 4, 2018, our fully insured group and retail HMO members **may** be required to pay for the **entire** emergency room (ER) bill if they go to an out-of-network ER as a convenience for a condition they don't think is serious or life-threatening.

- On May 1, 2018, we will send letters to members who have had an out-of-network ER claim letting them know more about their care options (see more details below).

- The review process for claims incurred after June 4, 2018, will be to:
  - Request medical records and an itemized bill for the claim. We will review each medical record to ensure the services our members receive are being accurately billed to eliminate inappropriate charges. As part of the review, the member's symptoms and concerns will be reviewed in connection with their HMO plan.
  - Pend – not deny – claims while we review the claim.
  - Review each claim using a multi-step process.

- A claim will not be denied without review by a licensed physician. Should the claim be denied, the member will have the same appeal rights that they currently have.

Member Communication Details

The letters being sent on May 1 are going to members who have had an out-of-network ER claim. It will explain the claims review process and their care options.

We want to make sure members receive the right care, at the right place and at the right time for the best health outcomes. We've spent the last few years educating members about where to go for the right level of care, and we will continue to do that through SmartER Care℠ Education Campaign.

For additional resources, go to:

- The SmartER Care website at smartercaretexas.com to learn more about where members can go when they need care.
- Our website at bcbstx.com. Click on the Find a Doctor link to search for a doctor or urgent care clinic close by.

A similar message will go out to employer groups. Please continue to educate your clients on their role in controlling the cost of health care and their options on where to get care.

If you have any additional questions, reach out to your account representative.

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