July 15, 2019

American Surgical Professionals (ASP) is a Houston based company that employs surgical assistants who serve as first assistants in certain surgical procedures, primarily in hospital based settings.

A surgical assistant, also known as a first assistant, participates in surgery, acting as the second hands of the surgeon within the sterile field and with hands-on the patient. To be in compliance with Texas rule, surgical assistants can include a doctor, a physician assistant, a registered nurse, a Licensed Surgical Assistant, a registered nurse first assistant (who has received specialized training in first assisting), a person who is certified by not licensed as a surgical assistant or a person with none of these qualifications.

Historically, surgical assisting duties were performed by a co-surgeon or other medical doctor. However, as the cost and availability of medical doctors have made it prohibitive for them to continue to serve in this capacity, more and more over the years the surgical assistant role has been assumed by other trained medical personnel.

Most of the surgical assistants employed by ASP are Licensed Surgical Assistants, licensed under Chapter 206 of the Texas Occupations Code. In order to be eligible for such licensure, Licensed Surgical Assistants are required to have at least an associate's degree, to have passed an accredited surgical assistant program, including a required clinical component, to have obtained a national certification from a certifying body acceptable to the Texas Medical Board and to have passed a national exam acceptable to the Texas Medical Board in surgical assisting. Applicants must have also obtained 2,000 hours of operating room time under the direct supervision of a surgeon, and the surgeon or surgeons for whom they have worked must certify their proficiency to the Texas Medical Board. Lastly, License Surgical Assistants are required to regularly obtain continuing education credit and are subject to discipline by the Texas Medical Board.

ASP provides the following feedback (in blue) in response to the questions posed by the Texas Department of Insurance (TDI):

**Issue 1: Nonemergency exemption**

SB 1264 allows a consumer to be balance billed for out-of-network nonemergency care if the provider gives the consumer "a complete written disclosure" that includes projected costs before providing the service.

**For consideration:** What rules, if any, are needed to provide adequate consumer certainty and protection?

- Should TDI rules define timelines for how much advance notice consumers must be given before receiving a service that may result in a balance bill? Surgical assistants generally do not have an opportunity to interact with the patient in advance of the procedure and therefore lack an effective means of providing a "complete written disclosure" in advance of the procedure. The rules should take this into account, preferably assigning the responsibility of

providing the disclosure regarding the surgical assistant's fee to either the facility or the surgeon, depending on which is responsible for assigning the assistant to work on the case.

- What specific information must the disclosure include to ensure consumers understand the potential out-of-pocket cost for the service? The information should include type of surgery to be performed and the surgeon's request that a surgical assistant participate in the procedure.
- What rules should TDI consider to prevent consumers from getting disclosures when they may be under duress? No response.

ASP question – SB 1264 provides that this exemption applies when the enrollee elects to undertake the procedure in writing following the disclosure. What constitutes "written election" by the enrollee?

**Issue 2: Arbitration process**

SB 1264 requires the arbitrator to provide the parties with a written decision no later than the 51st day after arbitration is requested, unless both parties agree to extend the deadline.

**For consideration:** What rules, if any, are needed to ensure procedural fairness and meet the strict deadlines set by SB 1264?

- Are there existing arbitration processes or models that should be considered? No response.
- To what extent should the process provide each party with an opportunity to rebut the information another party submitted to an arbitrator? The information provided to the arbitrator by each party should be made available to the other party. However, the ability to rebut the material provided by the other party should not present a requirement for production of materials through a discovery process and/or an opportunity for delay of the proceedings longer than the 51 days afforded by SB 1264.
- Are rules needed to address how and when the parties must notify TDI if they cannot agree on an arbitrator? No response.
- Are rules needed to address fees and standards for arbitrators? Fees should be stated upfront and not subject to variation. The fees should be kept low so as not to deter arbitration requests.

ASP additional feedback – Surgical assistants do not have their own CPT codes; rather, the assistant bills using the same codes used by the surgeon along with a "modifier" to designate that the provider was acting as an assistant rather than as the surgeon. Because the surgical assistant does not know what percentage of the billed charge the insurer will pay for the assistant at surgery, in practice the surgical assistant bills for the CPT code as though acting in the capacity of a surgeon, and the insurance company in turn heavily discounts the billed charge and pays only a small percentage of the billed charge.

Without going into too much detail, this billing process has been inherited from CMS guidelines and procedures for reimbursement of surgical procedures. Under those procedures, CMS reimburses surgical assistants a certain percentage of what the lead surgeon receives as reimbursement, depending on the qualifications of the surgical assistant (i.e. whether they are another physician or another type of healthcare professional).

Given this practice and, given that the "amount in controversy" in a single arbitration cannot exceed $5000, it is important that the surgical assistant be permitted to bundle claims based on the amount that the surgical assistant is actually requesting as payment, rather than the original amount billed. One way of accomplishing this may be to allow the surgical assistant, in submitting the arbitration request, to define the "amount in controversy" as the amount that the surgical assistant is willing to accept for the procedure, rather than the original billed amount.

Note that, because SB 1264 does not apply to ERISA plans, and because surgical assistants are not permitted to maintain more than one chargemaster in a particular geographic area, surgical assistants cannot adjust these longstanding billing practices for one market without also compromising the billing practices in other markets that are not subject to the same rules. Utilization of the "amount in controversy" in the manner described above would solve this conundrum.

**Issue 3: Payment standards and hold harmless provisions**

SB 1264 does not address nonemergency situations where a network provider is not reasonably available. In these situations, a health plan uses an access plan to address gaps in its contracted network. Current TDI rules establish payment standards for these situations to minimize balance billing to consumers and prohibit balance billing for HMO members.

> **For consideration:** What, if any, changes should be made to TDI rules for access plans to ensure consumers are protected from balance billing resulting from gaps in a health plan's contracted network?

ASP comment: Surgical assistants are generally out of network, either because insurers refuse to contract at all or refuse to contract at reasonable rates. ASP is unclear as to how TDI's rules for access plans apply to surgical assistant or are enforced by TDI.

**Issue 4: Benchmarking**

SB 1264 provides that the Insurance Commissioner may adopt rules governing the submission of information for the benchmarking database.

> **For consideration:** What rules, if any, are needed related to submissions of information to the benchmarking database and how that information is used? For example, are rules needed to define regions as they pertain to the requirement that the arbitrator consider "fees paid by the

health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the *same region*."

ASP comment/question: How is it to be determined what is a "similarly qualified" out of network provider? Since, in Texas, the qualifications of a surgical assistant can vary greatly, insurers should not be permitted to determine what similarly qualified means. If insurers were to make this determination, this would likely skew the numbers submitted to the lowest possible reimbursement level.

Likewise, how will it be determined what is meant by the "same or similar specialty" in determining percentiles to be applied? Will this be interpreted as applying to the job title or the job actually being performed? ASP believes this should be interpreted as the job function and not based on the title, as all of the practitioners are performing the same clinical job function in the operating room. An interpretation applying job title would be considered discriminatory and would likely be a violation of the intent of ERISA and ACA.

**Issue 5: Other considerations**

Are there other issues or considerations that TDI should be aware of when drafting rules related to SB 1264? Please be as thorough as possible in your responses to ensure all relevant information is considered as the agency develops rules in time for the law's January 1, 2020, effective date.

For ERS/TRS plans the usual and customary rate is as defined in the master benefit plan. Providers should have early, i.e. before surgery, and transparent access to the master benefit plans that apply. Currently, ASP does not have a method for obtaining such information as most commercial insurance companies are not willing to share this information.

SB 1264 requires the health benefit plan to provide notice to its enrollees that "a health care practitioner described by subdivision (1) may balance bill the enrollee for amounts not paid by the health benefit plan unless the healthcare or medical service provided to the enrollee is subject to a law prohibiting balance billing." What definition of balance billing applies to these provisions? Additionally, can providers receive a copy of the health plan's notice to confirm it was provided and to see what the notice contains?

Finally, if a database is selected for benchmarking purposes, what data will be used for the beginning of the process, beginning January 1, 2020, if the rules regarding provision of the benchmarking data have not been in place for a sufficient period of time prior to January 1, 2020 to offer an adequate and reliable benchmarking standard?