CPPP Center for Public Policy Priorities

December 3, 2012

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Via email: chiefclerk@tdi.state.tx.us and lhlcomments@tdi.state.tx.us

Re: Proposed Amendments to 28 Texas Administrative Code (TAC) Chapter 3, Subchapter X, Preferred and Exclusive Provider Plans

Dear Ms. Waitt and Mr. Danzeiser:

We appreciate the opportunity to comment on TDI's proposed amendments to network adequacy rules for preferred provider benefit plans (PPBPs) and proposed new rules regulating exclusive provider organizations (EPOs).

The Center for Public Policy Priorities is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core of our mission and activities since our founding. The center participated in several earlier steps in the PPBP network adequacy and EPO rulemaking processes, always with the goal of reducing or eliminating balance billing when no preferred provider is reasonably available to an insured.

We believe consumers deserve strong protections that ensure they are not liable for unexpected balance bills. As the Department is aware, balance billing is a troubling issue for PPBP enrollees. Even diligent consumers can end up being unexpectedly treated by an out-of-network provider and balance billed. We are especially concerned about consumers who are treated by out-of-network providers in emergency situations and hospital-based physicians in conjunction with care received at an in-network hospital. Take Andrea from Murphy, Texas for example. She was balance billed twice by out-of-network physicians who treated her son on an emergency basis at an in-network hospital. She ended up paying several hundred dollars in balance billed charges, only part of which was credited toward her deductible. Determined to prevent future balance bills, she called her insurance company only to learn that no emergency room doctor in the entire state was in her plan's network.

We believe that these proposed rules provide good protection against unexpected balance bills for consumers. We strongly support amendments directing insurers to credit the full amount consumers pay for balance bills toward their *in-network* deductible and out-of-pocket maximum in cases when consumers are forced to go out-of-network due to an emergency or because their network was inadequate to provide medically necessary covered services. Had this important protection been in place when Andrea from Murphy, Texas sought treatment for her son in a network with no emergency room doctors, she would have at least had the full amounts she paid out-of-pocket credited. And, under these rules, it is less likely she would have been balance billed in the first place, because the insurer would have been subject to network adequacy standards and would have had to pay the out-of-network emergency room doctor at least the usual and customary rate.

The center also advocated during the legislative session to strengthen HB 1772, which established EPOs. We believe that these products, new to the Texas fully insured market, must have sufficient consumer protections, including protections from balance billing, clear consumer disclosures, and adequate networks.

Because EPOs have no out-of-network benefits, it is imperative that their networks are robust enough to provide all covered services within a reasonable time and distance from enrollees. We continue to believe that because EPO insureds cannot go out-of-network, network adequacy standards for EPOs should be more stringent than they are or PPBPs. We have advocated that EPOs not be granted waivers under sec. 3.3707, as they can be under this proposed rule. We recommend a change that would allow waivers for EPOs, but hold them to a higher standard than for PPBPs.

Given the clear consumer protection concerns that arise from a closed network plan like an EPO, we are pleased to see and strongly support the addition of explicit language generally shielding EPO insureds from balance billing in the cases of emergencies and when consumers are forced to go out-of-network because their network is inadequate to provide medically necessary covered services.

Our specific recommendations include:

Sec. 3.3703(a)(27) and (28). We support these additions in general and believe they will help consumers be more aware of the possibility of balance billing, and importantly, help them avoid it.

- We understand the concern with the language about an insurer coordinating an insured's care in sec. 3.3703(a)(27)(A) and sec. 3.3703(a)(28)(A). We recommend that the language be changed to more accurately reflect the ability of the insured to contact the insurer for any help the insurer can provide in preventing an unexpected balance bill—from giving information on expected out-of-pocket costs and the availability of network providers to helping coordinate care so that it is performed by network providers.

- We recommend strengthening the notice provided from the facility to the insured in sec. 3.3703(a)(28)(A) by also requiring the contract to direct that facilities notify insureds of the contact information for the specific person or office within the facility who can provide information on expected charges and potentially help schedule care so that it is performed by network providers.

Sec. 3.3704(a)(12). We recommend adding "reasonably" to the provision as shown below.

> (12) if medically necessary covered services are not <u>reasonably</u> available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accord with the Insurance Code §1301.005 and §1301.0052, and §3.3708 and §3.3725 of this title, as applicable.

Sec. 3.3705(m). We support the annual policyholder notice about the use of a local market access plan, but recommend that the notice be improved to give consumers access to all relevant information on the waiver and access plan in one place. In addition to providing a link to the online listing of regions, counties, or zip codes where the network is inadequate, the notice should point consumers to two other important pieces of information: (1) how they can obtain or view the full local market access plan, and (2) a link to TDI's webpage on waivers that have been granted. Our suggested language is below.

(m) Annual <u>policyholder notice concerning use of a local market access plan</u> [~~Policyholder Notice Concerning Use of Access Plan~~]. An insurer operating a preferred provider benefit plan that relies <u>on a local market</u> [~~upon an~~] access plan as specified in <u>§3.3707</u> [~~§3.3709~~] of this <u>title relating to Waiver Due to Failure to Contract Local Markets must</u> [~~subchapter is required to~~] provide notice of this fact to each individual and group policyholder participating in <u>the</u> [~~such~~] plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include<u>:</u>

<u>(1)</u> a link to any webpage listing of regions, counties, or ZIP <u>codes</u> [~~Codes~~] made available pursuant to subsection (e)(2) of this section<u>;</u>[~~.~~]

<u>(2) information on how the local market access plan may be obtained or viewed; and</u>

<u>(3) a link to the department's website with information relevant to the grant of waivers established under §3.3707(f).</u>

We believe that the notice should identify how the local market access play may be obtained or viewed. As proposed, the notice provides a link to a listing of geographic areas where the network is inadequate, but the local market access plan contains additional information that will benefit consumers, including procedures that will be used to help insured access care. Policyholders will get information on how to view the local market access plan in the policy terms and conditions under sec. 3.3705(b)(14)(C), but we believe that including this information in the annual notice that is specific to the access plan will help insureds get all of the relevant information on the access plan in one place.

We further suggest adding the link to TDI's website that lists information relevant to waivers required under sec. 3.3707(f). We suggest below that TDI post the department's reason for granting the waiver and any supporting documentation online, and believe that consumers should be directed to this website in their annual notice so they can learn more about the good cause for granting the waiver, if they wish to.

Sec. 3.3707. In general, we support the additions to the network adequacy waiver requirements under this proposed rule and believe they will benefit consumers by helping to ensure that networks are adequate up front.

- We believe that the additions under Sec. 3.3707(b)(1)(A)-(E) are reasonable and appropriate requirements for insurers seeking a waiver of state network adequacy requirements and will provide TDI with information that is necessary for the commissioner to determine whether a waiver is warranted. These standards must be maintained in the adopted rule to ensure a meaningful review of waiver requests.

- We also support the addition of sec. 3.3707(c), which requires insurers to file a local market access plan at the same time as the waiver request. Ensuring that carriers have compliant local market access plans that are sufficient to help insureds access care in an inadequate network is an appropriate prerequisite for marketing a plan under a waiver. We also support secs. 3.307(g)(2) and3.3707(i), which require insurers to submit a local market access plan at the same time they submit a waiver request at renewal and if a network falls out of compliance with network adequacy standards.

- We support the addition of language in sec. 3.3707(f) which directs the department to post "information relevant to the grant of a waiver," along with specific pieces of information that must be posted. TDI should provide basic information to the public when it grants a network adequacy waiver, including the reasons for granting the waiver with relevant supporting materials and information on how insureds can obtain or view the insurer's local market access plan. We recommend the following additions:

(f) [~~(d)~~] If the department grants a waiver under subsection (a) of this section, the department will [~~shall~~] post on the department's website information relevant to the grant of a waiver, including:

(1) the name of the preferred provider benefit plan for which the request is granted;[~~,~~]

(2) the insurer offering the plan;[~~, and~~]

(3) the affected service area;[~~.~~]

(4) the reason or reasons the department found good cause to grant the wavier and any relevant supporting materials; and

(5) information on how the local market access plan may be obtained or viewed.

- We are confused with the language in sec. 3.3707(i)(1) that makes the local market access plan available to TDI upon request. Several provisions in sec. 3.3707 direct insurers to file the local market access plan with TDI including sec. 3.3707(i)(2), which instructs insurers how to file. We believe insurers should file plans with their waiver requests.

- We support the additions in secs. 3.3707(j) and (k), which outline minimum standards for local market access plans and related procedures and believe they should be maintained to protect consumers.

- In our comments on the proposed rule published on June 29, 2012, we supported the provision in Sec. 3.3707(g) preventing EPOs from applying to TDI to waive network adequacy requirements. That prohibition is not in these proposed rules. We continue to believe that with no out-of-network coverage, it is even more important that consumers in EPOs have access to an adequate network and that EPOs should be held to a higher standard when seeking a waiver than PPBPs. To do that, we recommend that TDI grant EPO waivers only when providers are not available to contract under sec. 3.3707 (a)(1). We understand that

there are regions in the state where certain provider types simply do not exist and that preventing EPOs from getting a waiver would result in consumers in those areas lacking access to EPOs. EPO waivers should only consider circumstances where no providers exist to contract.

This rule appropriately holds EPO insureds harmless when they get out-of-network care when no preferred provider is reasonably available. This provides good motivation for carriers writing EPO coverage to have adequate networks when it is possible. But limiting waivers only to circumstances where providers are not available provides additional protections for consumers. It should reduce how often EPO insureds are burdened with having to get approval to go out of network and subsequently tracking and submitting balance bills, and it would also reduce consumers out-of-pocket costs in some cases from the coinsurance rate applied to the billed charge or mediated rate under a waiver to the coinsurance rate applied to the contacted allows amount.

Sec. 3.3708(b)(1). We believe that these rules will benefit consumers by greatly reducing the incidence of balance billing, and where it still occurs, reducing the amounts of balance bills, in part due to the addition of sec. 3.3708(1), directing PPBPs to pay claims at the usual or customary charge when no preferred provider is reasonably available. Short of a legislative solution to end balance billing, TDI's regulatory approach to minimize balance billing appears to be as protective of consumers as possible.

We understand, however, that insurers are concerned that paying usual and customary rates will reduce the motivation for providers to contract and increase premiums. Though, we feel that these concerns may be overblown by insurers since these rules only address payment for claims when an insured involuntarily gets out-of-network care (incidences of which should be reduced by these rules), we also acknowledge that linking payments to billed charges could have some downsides for consumers.

We hope there are ways to mitigate any negative effects on consumers and still meaningfully reduce balance billing, but to do that, TDI must maintain a strong standard for the "floor" for payments paid from insurers to out-of-network providers when no preferred provider is available. Maintaining a floor will help encourage insurers to maintain adequate networks and reduce balance bills for consumers.

Insurers are concerned that linking payments to usual and customary charges will increase premiums. While no one wants premiums to go up, a more important consideration from a consumer perspective is whether we get value for our premiums. We believe that asking everyone to pay a bit more in fixed, monthly premiums to prevent a few people from getting unexpected, possibly financially crippling balance bills likely represents a good value for consumers, as long as premiums aren't higher than they need to be to prevent balance bills.

It stands to reason that non-preferred providers do not have to always receive their full billed charges to be considered paid in full. Balance bills certainly are not fully collectable, so at least in theory, an out-of-network provider should be willing to accept billed charges minus the rate of uncollectable balance bills and the administrative cost of balance billing. Thus setting the floor for payment at billed charges means that insurer (and consumers) would pay more than is needed to reduce balance billing.

We recognize that finding the right floor is challenging. We think that usual and customary provides the best protection against balance billing, which is a meaningful benefit in exchange for any premium increase. We would like to support a floor that is somewhere between the usual and customary rate and the higher of the average contracted rate or the average out-of-network allowed amount (TDI's 2009 Report of the Health Network Adequacy Advisory Committee showed the 4 of 5 PPBPs generally reported higher allowable payments for non-contracted providers than those for contracted physicians), but do not know exactly how to define it. The higher of the average allowed amounts will result in many more balance bills than usual and customary, but as noted above, usual and customary will likely raise premiums more than is necessary to reduce balance bills. We hope the department can find a good balance within this range that protects against unexpected balance bills.

We know carriers have raised concerns that requiring usual and customary will cause providers to leave networks. Insurer and provider motivation to contract is influenced by many factors today. These rules have several different moving parts that will affect these motivations, and until they go into effect, we won't know exactly what will happen. We encourage the department to actively monitor balance billing complaints, requests for mediation, and information submitted through network adequacy waiver requests to identify any trends of providers moving in or out of networks.

In summary, we fully support the department's attempt to set a floor for what out-of-network providers must be paid when no preferred provider is reasonably available as a means to reduce how often consumers are balance billed and the amount of balance bills. We believe that a floor provides a valuable consumer protection and that using

usual and customary as the floor will significantly reduce balance billing. If the department does not maintain usual and customary as the floor, we suggest the department look for a standard that sets the floor for these payments between the higher of the average allowed amounts and the usual and customary rate.

Sec. 3.3708(b)(3). We strongly support the amendments to this subsection which clarify that insurers must credit amounts consumers pay out-of-pocket in required cost-sharing and balance billing when a preferred provider is not reasonably available to the in-network deductible and out-of-pocket maximum. The amendments to this section clarify language on how consumer out-of-pocket costs should be credited, which will ensure consistency between insurers. Consumers will only encounter this scenario in emergencies or when their network is inadequate to provide a covered benefit they're paying for with their premiums. While we don't think PPBP consumers should be subject to balance bills at all when they involuntarily get care out of network, it is certainly appropriate in cases of inadequate networks and emergencies that all consumer out-of-pocket payments be applied to in-network cost-sharing limits.

During the July 16 and November 14 hearings on these and previous proposed rules, representatives from the Texas Association of Health Plans testified that the clarification in how out-of-pocket spending should be credited in §3.3708(b)(3) amounted to a state mandated benefit Texas may have to defray the cost of under section 1311(d)(3) of the Affordable Care Act, which requires that states cover the cost of state mandated benefits that exceed essential health benefits in qualified health plans starting in 2014. Federal rules have just been released that clarify that the amendments to §3.3708(b)(3) will NOT generate liabilities for the state (from the preamble to Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, CMS-9980-P, emphasis added):

> HHS received many comments in response to the EHB Bulletin about how state-required benefits beyond EHB could be identified and how states would defray the cost of those benefits. In this proposed rule, we interpret state-required benefits to be specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. *Therefore, state rules related to provider types, cost-sharing, or reimbursement methods would not fall under our interpretation of state-required benefits.* Even though plans must comply with those state requirements, there would be no federal obligation for states to defray the costs associated with those requirements.

Division 2. As noted above, we believe that because EPO insureds cannot go out-of-network, network adequacy standards for EPOs should be more stringent and balance billing protections more robust than they are or PPBPs.

Sec. 3.3725. During the legislative session, we raised concerns about the possibility that EPO enrollees would face balance bills if they got out-of-network care in an emergency or when the network was inadequate to provide access to a medically necessary covered service. In these cases, the circumstances that caused the insured to get out-of-network care were beyond the enrollee's control.

- In an emergency, people need to seek the most immediate care, which may be in an out-of-network hospital. In other cases, the enrollee goes to an in-network hospital but is seen by an out-of-network ER physician, surgeon, etc. In an emergency, patients do not have the ability to ensure that hospital-based physicians are in their network.
- If an insured has to get a covered service out-of-network because the service is not available in network, it will be a direct result of a health plan failing to maintain an adequate network for covered services as required by law. EPO enrollees pay premiums with the promise of access to preferred providers for covered services. Enrollees should not be subject to balance billing when the health plan's network is insufficient to deliver covered services.

To prevent EPO balance billing, the legislature added language to HB 1772 that mirrors HMO language for payment of claims in emergencies and when no network provider is available. The legislative intent of adding this language as communicated to us was to extend HMO balance billing consumer protections to EPOs, as advocated by consumer groups. EPOs, just like HMOs, have closed networks with coverage only for preferred providers, except in cases of emergency or inadequate network. State law prevents HMO enrollees from being balance billed; instead, the HMO makes the out-of-network provider whole, either by negotiating an agreeable rate with the provider or paying the provider's billed charge. From what we can tell, this long-standing practice seems to be working fine.

We strongly support language in §3.3725(d) and (e) that makes explicit the obligation of the EPO to generally hold the insured harmless for amounts beyond in-network cost-sharing if an insured cannot reasonably reach a preferred provider or covered services are not available through preferred providers. Maintaining this language will appropriately provide EPO insureds with the same level of consumer protections as HMO enrollees as it relates to balance billing.

As we expressed previously, we have some concerns about the process allowed under §3.3725(c)(3), in which an insured would not be held harmless if his/her insurer provided a list of three nonpreferred providers and the insured did not select one of them. It is fine to allow an insurer to assist an insured with finding a nonpreferred provider, but we don't support exceptions to hold harmless protections for EPO insureds.

We expressed concerns previously about the ability of EPOs to contractually require a consumer to go to mediation under sec. 3.3725(e)(2) if they are held harmless for a balance bill that would qualify under the mediation statute. The department addressed our concerns in this proposed rule with the addition of language in sec. 3.3725(e)(2)(A)(i) – (iii). We believe secs. 3.3725(e)(2)(A)(i) – (iii) provide reasonable protections for consumers and insurers, and that sec. 3.3725(e)(2) will benefit consumers by providing a mechanism for providers and insurers to negotiate bills.

Thank you again for the opportunity to provide comments. If you have any questions related to our comments, please feel free to contact me at (512) 320-0222 ext. 117 or pogue@cppp.org.

Sincerely,

Stacey Pogue
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