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The Value of Health Plan Networks

January 28th, 2016

JAMIE DUDENSING, CEO

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The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas.

- Health plans - employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid
- 28 Health Plan Members, including the 20 Medicaid Health Plans
- Dental Medicaid Managed Care Organizations, Pharmacy Benefit Managers, Behavioral Health Organizations, Transportation Management Organizations
- TAHP advocates for public and private health care solutions that improve the affordability, accessibility and accountability of health care for many Texans

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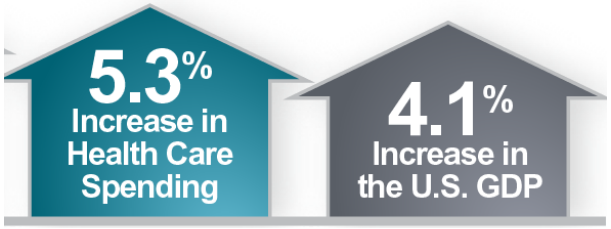
Why Networks Are Important

Rising Health Care Costs

- **$3.1 Trillion on Health Care in US in 2014**
  - 5.8% growth per year for the next decade
  - 2014: $1 in $6 was spent on health care
  - By 2024: $1 in $5 will be spent on health care

2014 U.S. Health Care Spending



Health Plan Networks - Where Competition Happens in Health Care

- **Networks Hold Down Costs**
  - Contracted Rates vs. Billed Charges
  - Size of Network (5% to 20% Savings)
- **Networks Promote Quality**
- **Networks Protect Consumers From Surprise Billing and Inflated Billed Charges**

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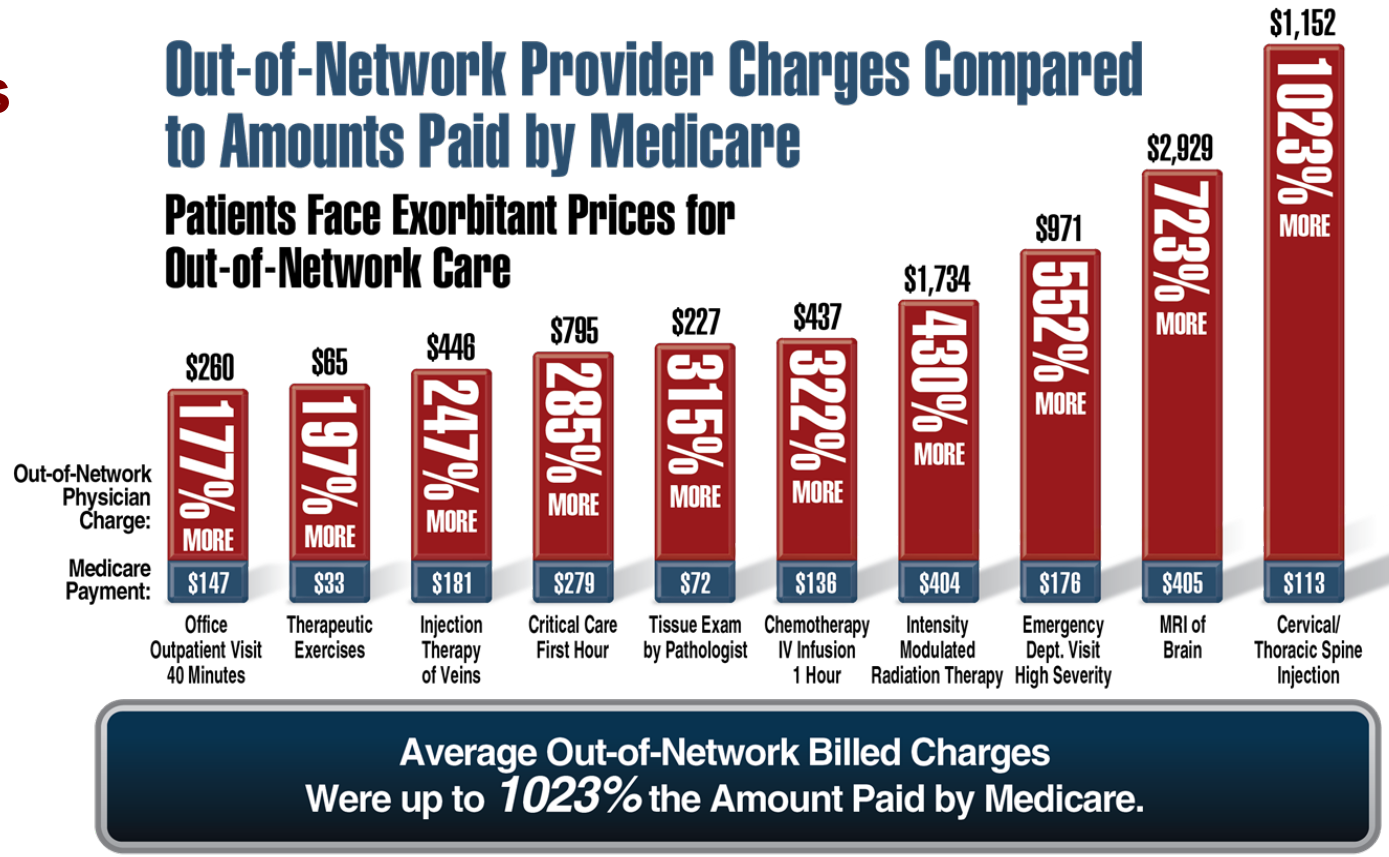
Problems with Billed Charges

- No limit to what a provider can charge
- Self-determined
- No connection to underlying costs or market prices
- Huge variability in the same market – Knee replacement in Austin can cost anywhere from $17K-$28K (Yale)



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When Providers Choose to Be In-Network

- There is a contract between the provider and the health plan
- Providers have agreed to see covered patients
- They have agreed to accept the health plan's contracted rate
- They have been selected based on the health plan's standards and requirements to ensure quality and safe care
- Providers agree not to "balance bill" patients
- Providers benefit from the volume of patients that are covered by the health plan

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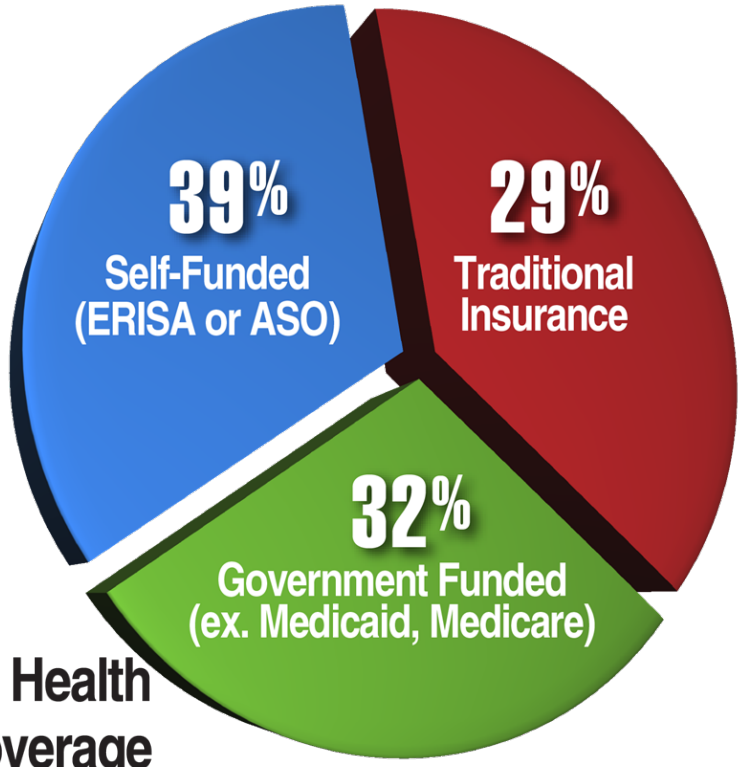
Three Types of Coverage

- **Traditional or Commercial Insurance**
  - Full Risk, Premium, Regulated by TDI (only market regulated by TDI)
- **Self-Funded or ERISA Plan**
  - Employer Takes on Risk
  - Health Plan or TPA
  - Regulated by ERISA (Feds, not TDI)
- **Public Insurance**
  - Medicaid
  - Medicare
  - Military



Texas Health Plan Coverage Sources in 2013

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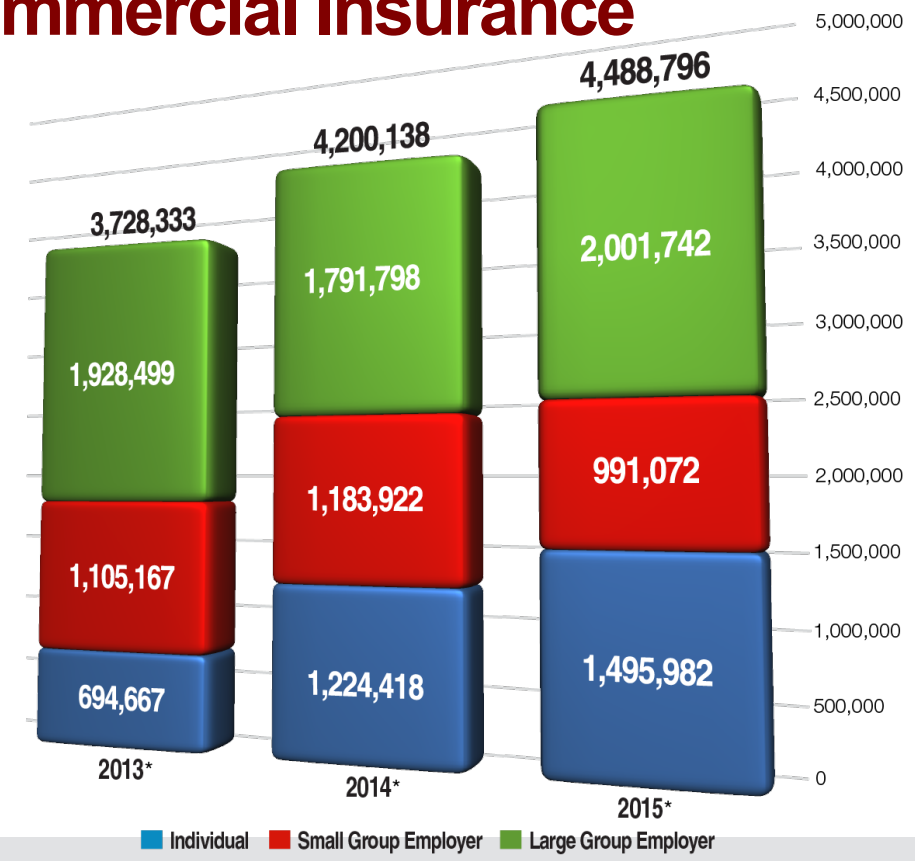
Three Types of Markets: Commercial Insurance

- **Regulated by TDI**
- **As of mid-2015:**
  - 1.4 million Texas with Individual Coverage
  - 1 million with Small Employer Group coverage
  - 2 million with Large Employer Group coverage
- **Individuals can purchase plans off of the Exchange**
- **Most coverage is Employer-Sponsored**



*Note: Data as of 12/31/2013, 12/31/2014, and 7/31/2015.
Source: Texas Association of Health Plans: Enrollment Survey 2015, Milliman, Dec. 2015

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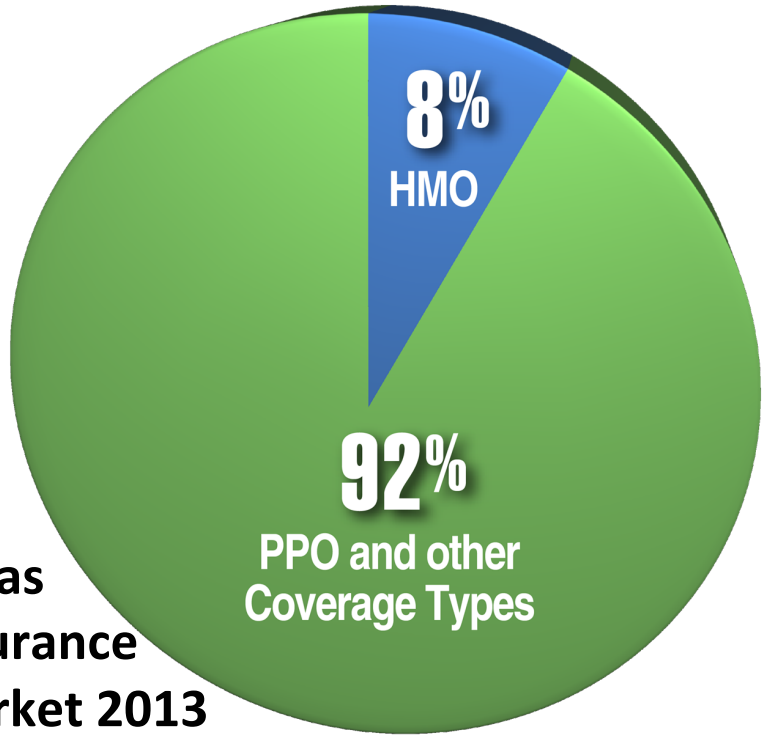
Three Types of Commercial Products in Texas

- **PPO**
  - Most Purchased
  - Higher Premiums
  - Out-of-Network Benefits
  - No Referrals
- **HMO**
  - No Out-of-Network (Except ER)
  - Referrals
- **EPO**
  - No Out-of-Network (Except ER)
  - No PCP Referral Requirement



Texas Insurance Market 2013

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Consumer Trends

- Individuals purchasing plans prefer less costly, narrow network plans over more expensive plans with broader networks (Kaiser Poll)
  - 54% vs. 35%
- Individuals with employer-sponsored coverage prefer broader networks over narrow networks (employer is purchasing the coverage/shields consumer from cost) (Kaiser Poll)
  - 55% vs. 34%
- Insured consumers satisfied with their health plan, cost, and their provider network (71% satisfied with plan, 61% said their coverage was excellent or good given cost) (Kaiser Poll)
- 88% of consumers satisfied with the selection of providers from their health plan (Kaiser Poll)
- Only 12% have had to change MD in last 12 months (half of them said it was not a problem or a small problem) (Kaiser Poll)

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Consumer Protections

- Network Adequacy Regulations
- Transparency About Cost, Fees, and Network Status
- Out-of Network Payment Protections
  - Inadequate Network
  - Emergency Care Situations
- Mediation Protection from “Surprise Billing” or Balance Billing
- All Health Plan Networks Must Be Adequate Regardless of Size
- TDI Has Adopted Some of Strongest Network Adequacy Requirements in the U.S.

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Network Adequacy: Regulating Networks

- **Health plans are regulated through network adequacy requirements**
  - State and Federal Laws
- **Plans are required to have a sufficient number of and type of providers to ensure that all covered services are available without reasonable delay**
- **Three Common Standards:**
  - Access (Distance or Time)
  - Adequacy – Numbers of providers
  - Appointment Availability – Wait times

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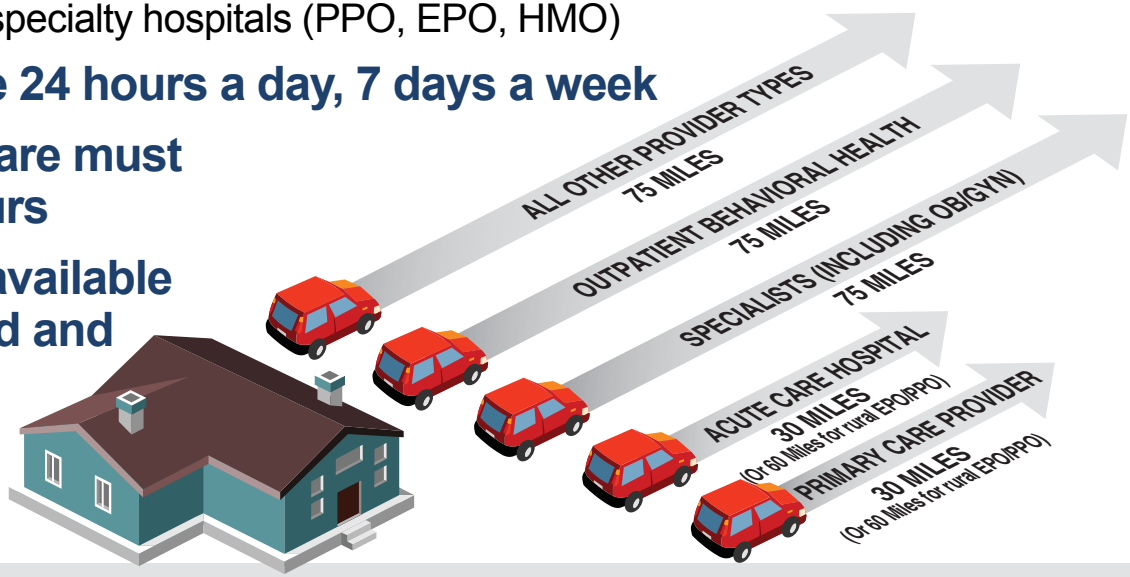
TDI Rules - Network Adequacy Protections

- **Maximum distance from any point in a health plan's service area:**
  - 30 miles for primary care and general hospital care (PPO, EPO, HMO)
  - 60 miles for primary care and general hospital care in rural areas (PPO, EPO)
  - 75 miles for specialists and specialty hospitals (PPO, EPO, HMO)
- **ER care must be available 24 hours a day, 7 days a week**
- **Non-emergency, urgent care must be available within 24 hours**
- **Preventive care must be available within 2 months for a child and 3 months for adults**



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Health Plan Transparency Protections

- **Estimate of Payment**
  - Any deductibles, copays, coinsurance, or other costs (upon request of consumer, within ten days)
- **Written notice to consumers that:**
  - Facility based providers may be out-of-network, even though they are at an in-network facility
  - Consumers may be charged the difference between what the health plan paid and the provider's full billed charges
- **Health plan provider directory and web site must clearly identify network hospitals in which facility-based physicians are not in the network.**
- **Must identify payment to a non-network physician (EOB)**
- **Health plans report aggregate reimbursement rates, billed charges, aggregate contracted rate (for in-network providers) and aggregate allowed amount (for non-network providers) to TDI.**
- **NOTE: Very few provider transparency requirements related to billed charges (prices) or network status**

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Consumer Out-of-Network Payment Protections

- **If a network provider is not reasonably available or for emergency care, PPO plan must:**
  - Pay usual or customary charges
  - Pay in-network level of benefits (in-network coinsurance level)
  - Credit any "balance billing" amount to the non-network deductible and annual out-of-pocket maximums
  - **Provider can still send a balance bill**
- **TDI enforces "hold harmless" protections against balance billing for EPO and HMO plan enrollees**

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Understanding Out-of-Network Situations

FIRST CHOICE EMERGENCY ROOM

THE NATION'S OLDEST AND LARGEST FREESTANDING EMERGENCY ROOM SYSTEM.

INSURANCE: HOUSTON/AUSTIN/SAN ANTONIO

First Choice Emergency Room is a free-standing emergency room. We function just like a hospital based emergency room. We will accept your ER co-pay at the time of service, and emergency room claims will be submitted to your insurance carrier.

We are not currently contracted with your insurance company. However, in the state of Texas, all emergency visits are to be processed as in-network regardless of the network status. What that means is your visit will be processed under your in-network benefits. Your insurance may not process it correctly the first time but our patient accounts department will work with them to have your claims reprocessed until they are processed under your in-network emergency room benefits. We accept all major, commercial insurance carriers like, but not limited to, AETNA, BCBS, Cigna, Humana, and United Healthcare.

If you have specific questions about your bill, please call our patient accounts team at the appropriate phone number below, weekdays between 8am and 5pm.

Houston/Austin/San Antonio (844) 564-2177

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Understanding Balance Billing: Two patients with sprained ankles enter the ER of an In-Network hospital

	In-Network	Out-of-Network
Billed Amount From ER Doctor	$1,050	$1,050
Insurer's in-network contracted amount agreed to in advance	$500	N/A
Insurer's required out-of network payment based on what is usual and customary	N/A	$600
What your insurer pays	80% Coinsurance $500 x 0.8 = $400	80% Coinsurance $600 x 0.8= $480
Your coinsurance/cost sharing (same in-network and out-of-network)	20% Coinsurance $500 x 0.2 = $100	20% Coinsurance $600 x 0.2=$120
Balance Bill: *Difference between what the insurer paid (usual and customary) and what the physician charged*	None	$1,050 - $600 = $450
Total amount you owe: *Your coinsurance and balance bill*	**$100**	$120+$450 = **$570**

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Mediation Protection From Surprise Bills

Currently, an individual may request mediation of a non-network balance bill if all of the following are met:

- **PPO or EPO plan or the State ERS plan (TRS was not included)**
- **Non-network hospital-based physician at a network hospital**
  - Radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon
- **"Balance bill" amount is more than $500**
- **No notification of projected costs, or the amount billed to the consumer exceeds the projected amount**

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KEY ISSUE: "Balance Billing"

- **Out-of-network problem –Provider bills a patient for fees that exceed what insurance paid (U&C)**
- **Mediation is working, but it is limited**
  - $500K threshold (SB 481)
  - Limited to 5 physician types (out-of-network at an in-network facility)
  - No facility protection, limited provider protection, & no ambulance protection
- **Balance billing continues to be a problem**
- **Solutions:**
  - Expand Mediation
  - Increase Transparency - Enhance non-network provider disclosure requirements & fees

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KEY ISSUE: Usual or Customary Charges

- **TDI requires health plans to pay out-of-network providers based on billed charges, the "usual or customary charge" for network adequacy issues and emergency care**
- **Based on billed charges, not what is usually accepted in the market**
- **Creates a financial incentive for providers to choose to stay out-of-network**
  - Many ER docs have left network, very few freestanding ERs are in-network
  - 21% to 56% of hospitals have no in-network ER doc at in-network hospitals for the three largest plans in TX
  - Providers can still balance bill in excess of U & C
- **Solutions:**
  - NAIC Recommendation: Median in-network rate or a percentage of Medicare payments
  - Mediation instead of requiring payments based on billed charges

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KEY ISSUE: Freestanding ERs

- **Out-of-network problem**
- **Can be very confusing for consumers**
- **Provider bills a patient for fees that exceed what insurance paid (U&C)**
- **Balance billing continues to be a problem**
- **Solutions:**
  - Expand mediation to freestanding ERs
  - Enhance transparency requirements for network status and fees

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Recommendations

- Increase transparency (freestanding ERs, provider facility fees, provider network status)
- Expand mediation
- Ensure that payment requirements do not incentivize providers to stay out-of-network
- Allow flexibility for health plans to implement alternative payment and delivery system reforms to improve quality and reduce costs
- Avoid government mandates that reduce competition, increase cost, and reduce consumer choice

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