TAHP
The Texas Association of Health Plans

Representing health insurers, health maintenance organizations, and other related health care entities operating in Texas.

The Value of Health Plan Networks

What are Provider Networks?

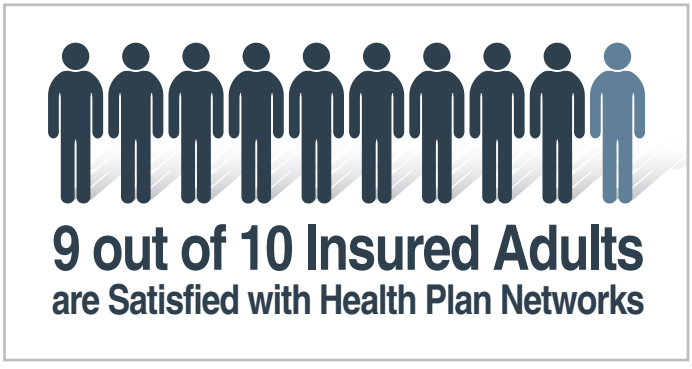
One of the most misunderstood and most important parts of health insurance and health care generally is the role of "provider networks" – a system of doctors, hospitals, and other providers that health plans have contracted with to provide health care services for their enrollees.

Health plans create provider networks by establishing agreements with a wide range of providers and facilities: doctors (including primary care-type physicians and specialists), hospitals, labs, radiology facilities, pharmacies and other providers. It is estimated that approximately 90 percent of U.S. providers (hospitals and doctors) participate in health plan networks. For providers, these agreements include commitments to participate in plans' quality and utilization management programs and to accept contracted rates as payment in full for covered services, in exchange for the volume of covered patients and administrative efficiencies.

Health plans develop provider networks that offer consumers and employers access to affordable, high-quality care. Some insurance products include broad networks that open up the network to a larger number of providers. Others include high-value networks, sometimes called narrow networks, which limit the network to high-performing and high-value hospitals and providers. A broad network usually means a more expensive health insurance premium, while high-value networks tend to have more affordable premiums. Regardless of network size, all health plans must meet federal and state regulations for network adequacy for health coverage.

Efforts by health plans to achieve high-quality provider networks are making a positive difference, according to new research from Kaiser Family Foundation. A poll released by Kaiser finds that 9 out of 10 insured Americans are satisfied with their choices of doctors and the value of their health plans.

In Texas, the Texas Department of Insurance (TDI) has adopted some of the strongest network adequacy requirements in the U.S., including mileage and appointment access requirements, non-network provider payment protections, consumer protections, and increased reporting and transparency requirements regarding non-network provider status and consumers' out-of-pocket costs.



When Providers Choose to be Part of a Health Plan's Network:

- They have agreed to see patients covered by that insurance carrier.
- They have agreed to accept the health plan's contracted rate, which helps keep coverage affordable.
- They have been selected based on the health plan's standards and requirements to ensure that consumers receive quality and safe care.

The resulting networks not only provide quality control and predictable, affordable rates, they also protect patients and consumers from excessive costs due to surprise out-of-network charges, known as "balance billing."

When providers choose not to participate or do not meet the requirements to be in a health plan's network, they may charge whatever fee they choose, called "billed charges," with some charging amounts that can be several hundred or even thousands of times greater than the Medicare payment rate for the same service.

Why Do Health Plans Use Provider Networks?

Provider networks help contain health care costs, because health plans can use private market competition to negotiate better prices with doctors and hospitals in the network. Health insurance premiums track directly with the underlying cost of care. As a result, lower prices from network providers mean that employers and individuals pay less in premiums and other charges. The providers in the network agree not to bill patients for more than the amount negotiated between the health plans and the provider (the contracted rate). In exchange, network providers receive a volume of health plan members as patients.

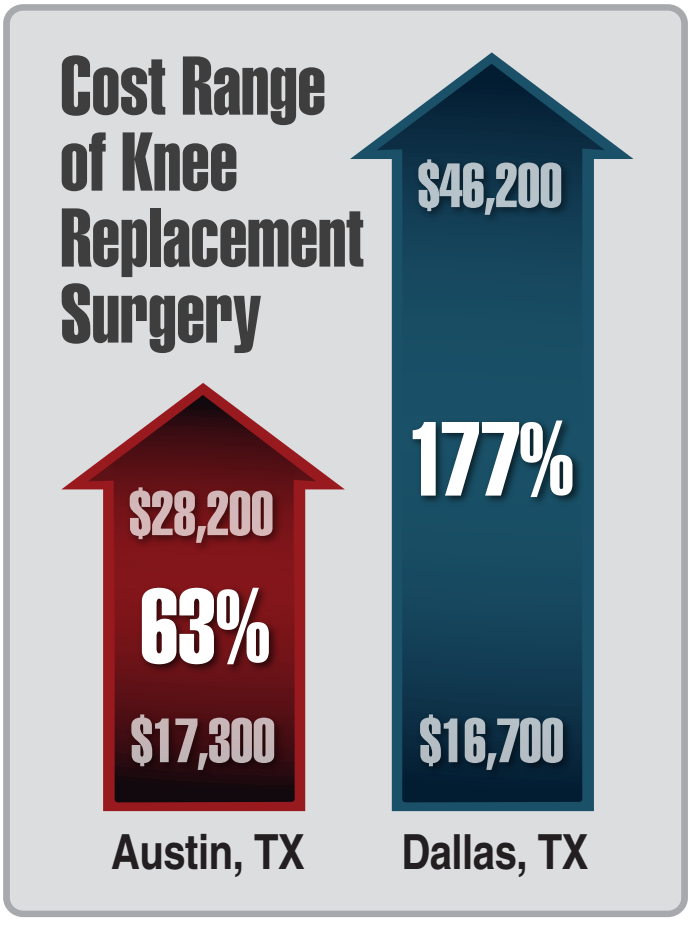
Networks Hold Down Costs

The negotiation process used in developing provider networks is the most important tool health plans have to help keep costs down for employers and individual consumers. Through private market competition, health plans negotiate a number of terms with providers; chief among them are affordable rates that in-network providers agree to charge covered consumers for their service. They agree not to bill patients for more than the amount negotiated with their contracted health plan. In exchange, providers receive a volume of health plan members as patients and administrative efficiencies.

The prices for medical care can vary widely even within the same market. Consider a recent study by a team of researchers from Yale, The University of Pennsylvania and other elite institutions, which examined the prices for medical services across the country. The report found not only a wide range of prices for medical care across the country but even within the same community. For example, knee-replacement surgery in Austin, Texas, ranges anywhere from $17,300 to $28,200, depending on the hospital. In Dallas, the same procedure can range from as little as $16,700 to as much as $46,200, depending on the hospital.

Given this wide range, it is increasingly important for health plans to be able to negotiate affordable prices with providers and facilities that are in their networks to ensure lower premiums and more affordable rates for their consumers, as well as more predictability.

Additionally, a smaller network can significantly lower premium costs for individuals and employers. A recent report by national research firm Milliman found that health plans with high-value provider networks—or plans that have limited their networks to high-performing providers—have premiums that are 5 percent to 20 percent lower than broader network plans.



Networks Promote Quality, Efficiency, Safety, and Choice

Health plans evaluate doctors, hospitals, and other providers for quality and safety before including them in their networks. This involves ensuring that facilities and providers meet patient safety goals and credentialing standards. By doing so, networks guide consumers to high-performing doctors and hospitals that provide cost-effective and high-quality care. These efforts by health plans help to ensure consumers receive the best value for their health care dollars.

Provider and Facility Criteria Considered By Health Plans Include:

- Quality of care standards
- Medical licensure
- Scope of practice
- Professional competency and conduct
- Training
- Academic background
- Board certification
- Hospital privileges

Provider Networks Protect Patients from Unexpected and Excessive Costs Due to "Balance Billing"

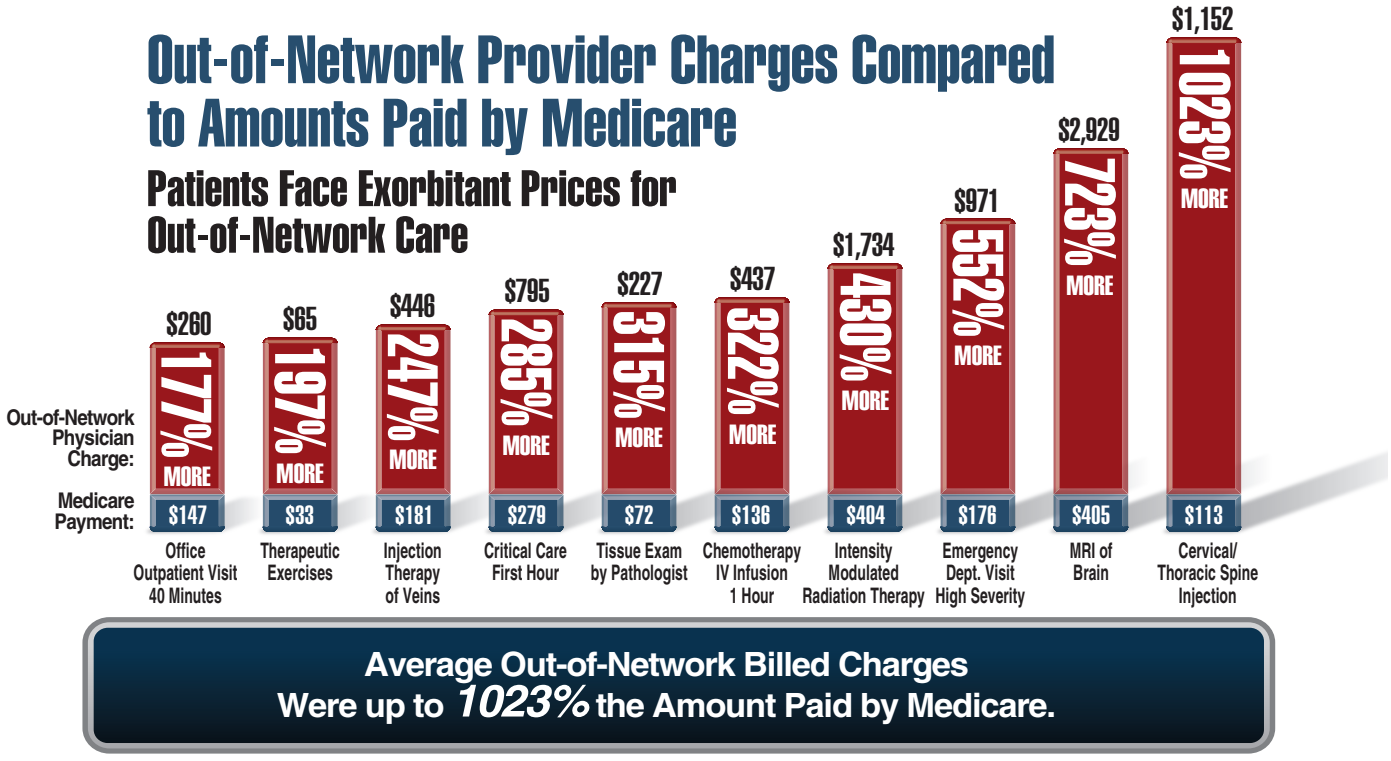
Balance billing is a growing practice occurring in Texas and across the country that has become synonymous with "surprise medical bills." Surprise balance billing occurs when insured patients receive out-of-network care, and the non-network doctor, facility or other health care provider who treats them bills them for fees that exceed the amount covered by their insurance.

In these out-of-network instances, there is no contract between the provider and the health plan, meaning there is no negotiated rate. Therefore, the health plan will pay their out-of-network reimbursement rate to the provider. In most cases, at this point, consumers believe their bill has been paid. But, because there was no negotiated rate, the provider will send a second bill (balance bill) to the consumer for the difference between what the health plan paid and the facility/provider's "billed charges." Billed charges are the price a facility or provider sets for their services. There is no legal limit to the price they can set, and these charges often have no connection to underlying market prices, costs, or quality.

Especially troublesome are large "surprise" balance bills that consumers receive from physicians who practice at an in-network hospital but who do not contract with the health plan. These facility-based physicians include ER doctors, radiologists, pathologists, anesthesiologists, neonatologists, and assistant surgeons, who typically have exclusive access agreements with the hospitals.

To the contrary, providers who have contracted to be in a health plan's network have negotiated payment rates with that health plan and cannot charge any additional costs to enrollees.

Balance billing is a growing problem in the U.S. but especially in Texas where some consumers are receiving **ER bills for high acuity care that are 650% higher than the Medicare rate.** (AHIP)



(This graphic comparison is not to actual scale as the difference would be difficult to interpret on a single page.)

Source: America's Health Insurance Plans, "Charges Billed by Out-of-Network Providers: Implications for Affordability." September, 2015.

Types of Health Plan Coverage: In-Network & Out-of-Network Coverage

There are typically three types of products available through commercial insurance in the State of Texas: **HMOs**, **PPOs**, and **EPOs**.

PPO plans are the most common commercial product in Texas. Consumers typically pay higher monthly premiums for PPOs because they cover some portion of out-of-network costs and do not require a referral. Although PPO consumers can usually go to any doctor they choose, their out-of- pocket costs will be lower if they use doctors and other providers in the PPO's network. They will typically pay more if they receive care from a physician or hospital that is not in the health plan's network because the health plan will cover a lower percentage of costs. Doctors and hospitals in a PPO's network have agreed to accept a discounted price for services to the PPO's members. Out-of-network doctors and hospitals have not agreed to the discounted prices and often charge more than what a consumer's PPO plan will pay for care.

HMOs provide lower monthly premiums because coverage is limited strictly to doctors or hospitals that are in-network and HMOs may require referrals. There is no out-of-network coverage with the exceptions of coverage for out-of-network emergency situations and when a network provider is not reasonably available.

An **EPO** plan is a relatively new product in the Texas market. It is similar to an HMO because it also has out-of-network coverage restrictions, and the premiums are more affordable. However, it does not require a patient to choose a primary care physician.

What is Network Adequacy?

Health plan networks are regulated through "network adequacy" requirements, which refer to a health plan's ability to deliver plan benefits by providing reasonable access to a sufficient number of contracted network providers. State laws, as well as federal regulations under the Affordable Care Act, establish network adequacy requirements that ensure consumers have access to a broad array of physicians and hospitals in health plans' provider networks. Plans are required to have a sufficient number and type of providers to ensure that all covered services are available without reasonable delay.

Health plans evaluate the sufficiency of their networks to meet the needs of consumers primarily through three standards:

- **Access** – Usually presented in distance or time, access is a way of measuring the distance between provider offices and member locations.
- **Adequacy** – Often presented in ratios of providers per members or members per providers, adequacy is a way of measuring whether a network has enough providers to meet the needs of the population.
- **Appointment Availability** – Often presented in terms of the wait times for an appointment or measuring the number of appointments available for routine visits within a given time period. Health plans measure performance against this standard through placing secret shopper calls to providers, surveying members, and researching complaints.

Texas Network Adequacy Requirements

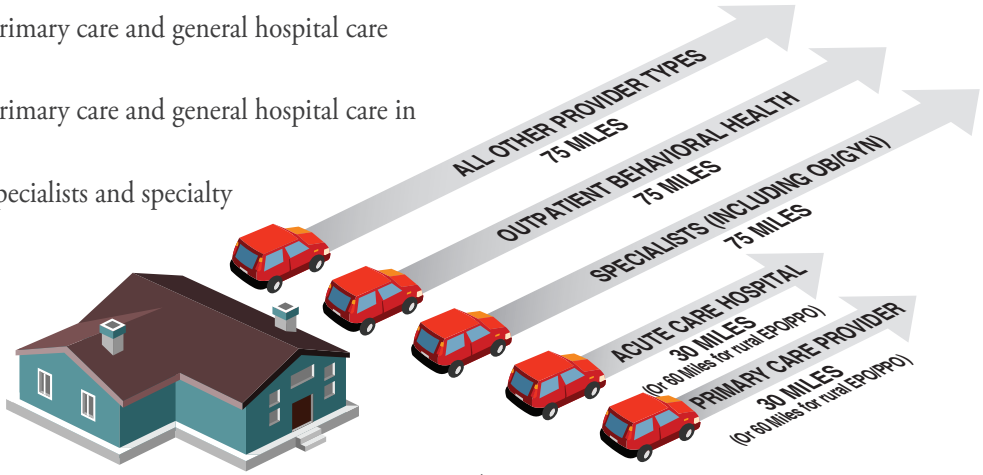
TDI rules specify maximum times in which care from network providers must be available and distance requirements that must be met from any potential patient's residence.

EPO & PPO Distance Requirements:

- Within 30 miles for primary care and general hospital care (non-rural areas)
- Within 60 miles for primary care and general hospital care in rural areas
- Within 75 miles for specialists and specialty hospitals

HMO Distance Requirements:

- Within 30 miles for primary care and general hospital care
- Within 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers



EPO & PPO Wait Times:

- 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
- Appointment for medical conditions must be available within 3 weeks
- Appointment for behavioral health conditions must be available within 2 weeks

HMO Wait Times:

- ER care must be available 24 hours a day, 7 days a week
- Preventive health care must be available within 2 months for a child, 3 months for an adult, and 4 months for dental services
- Routine care must be available within 3 weeks for medical conditions, 8 weeks for dental conditions, and 2 weeks for behavioral health conditions
- Urgent care must be available within 24 hours for medical, dental, and behavioral health conditions

A network will be considered "inadequate," in violation of the standards, and requiring a Commissioner's waiver if those access requirements are not met for ALL physician specialty types. Because of provider shortfalls in most areas of the state, particularly for physician specialists, every health plan offering a statewide network is required to request and obtain a waiver from some of the access requirements from TDI. TDI may find "good cause" to grant a waiver if the health plan demonstrates that providers or physicians necessary for an adequate network are not available or have refused to contract on reasonable terms. When requesting a waiver, the health plan must also file a network access plan explaining how it will help consumers obtain services and how out-of-network benefit claims will be handled when no network provider is reasonably available.

Despite the shortage of providers in the state, TDI receives relatively few complaints regarding the availability of network providers in a geographic area.

Network access issues are rare *EXCEPT* in areas with insufficient specialty physicians and services involving non-network, facility-based physicians practicing at in-network hospitals, often happening in emergency care situations. These facility-based physicians generally have exclusive arrangements with the hospital and less incentive to join networks.

Protections for Providers and Consumers in Out-of-Network Situations

Out-of-Network Protections

TDI's protections ensure consumers receive in-network levels of coverage, and that providers receive fair payment if a network provider is not "reasonably available" or in emergency care situations. However, these requirements are inconsistent, vary by coverage type, and in some situations, provide incentives for providers to stay out of network. In those situations involving PPO coverage, health plans must pay a non-network provider at the usual or customary charge and at the same benefit level as a network provider. For PPOs, TDI rules require:

- Pay the claim at the usual or customary charges for the service area.
- Provide coverage at the in-network level of benefits (in-network "coinsurance" level, 80/20).
- Credit any "balance billing" amount paid by the consumer to the non-network deductible and annual out-of-pocket maximums.

For EPOs and HMOs in similar situations, health plans must pay a usual and customary rate and the consumer is held harmless from balance billing.

Out-of-Network Protections

Type of Plan	Out-of-Network Coverage	Out-of Network Payment Requirements (Texas)	Out-of-Network Payment Requirements (Federal)	Out-of-Network Benefit Coverage Protection	Balance Billing Protection
HMO	• Emergency Services • No Network Provider Is Available	• Usual and Customary Rate	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• In-Network Benefit Level (co-insurance percentage ex. 80/20)	• Hold Harmless
PPO	• All Covered Services	• Emergency Services & No Network Provider is Reasonably Available: Usual or Customary Charge (TDI Rule) • All Other Services: Allowable Rates	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider Is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20); credit balance billing amounts paid by enrollee to network deductible and out-of-pocket max • All Other Services: At Least 50% Benefit Coverage	• Physician Services Only: Mediation For OON Hospital Based Physicians (6 types) – Balance Bill Over $500 • No Additional Balance Billing Protection for Any Other Services
EPO	• Emergency Services • No Network Provider is Reasonably Available	• Usual and Customary Rate	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• In-Network Benefit Level (co-insurance percentage ex. 80/20)	• Hold Harmless
ERISA Self-funded Plans	• N/A	• N/A	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• In-Network Benefit Level (co-insurance percentage ex. 80/20)	• No Additional Federal Balance Billing Protection

While it is vital to protect provider payments for emergency care and when the network is inadequate, this payment protection should not create an economic incentive that overly encourages providers to refuse to participate in health plan networks. Current TDI rules require health plans to pay out-of-network providers a rate based on billed charges, the "usual or customary charge" for the area in emergency situations and when a network provider is not reasonably available. This means the state agency has set reimbursement rates for these situations based on average billed charges, not based on what is actually accepted by providers in the market. Billed charges are self-determined by providers, have large amounts of variation, and often have no connection to underlying market prices. There are no limits to the amounts providers can unilaterally set as their billed charges. Because the rules require payment based on average billed charges, which are generally much higher than payments actually accepted in the market, providers have an economic incentive to stay out-of-network and be paid substantially higher reimbursement rates. This incentive is particularly strong with freestanding ERs, which consumers often confuse with less-expensive urgent care clinics and with hospital-based physicians, who virtually have monopolies within hospitals based on their exclusive privileges.

Additionally, since there is no network contract requiring a non-network provider to accept a negotiated contract rate as payment in full, non-network providers can also balance bill consumers over and above the plan's usual or customary charge benefit payments, up to whatever amount the providers have chosen as their billed charges. This puts consumers at risk for balance billing and increases the cost of health care premiums for consumers and employers.

The Texas health care market has already experienced unintended consequences of this rule. For example, following TDI's adoption of the "usual or customary charge" reimbursement requirement, many ER physicians have demanded higher contract rates or dropped out of health plan networks. Last year, the Center for Public Policy Priorities found that up to 56 percent of in-network Texas hospitals have an ER physician group that does not participate in at least one of the health plan networks that include the hospital.

Freestanding ERs are also taking advantage of these higher payments based on billed charges, and many have adopted a business model of not being in any health plan networks. This allows the freestanding ERs to balance bill enrollees up to the full amount of their billed charges, and current state law does not provide an opportunity to mediate these claims, even for balance billing amounts over $1,000.

The National Association of Insurance Commissioners (NAIC) has recommended an alternative to using billed charges as the standard for adequate payment for emergency care. The NAIC model act on network adequacy recommends a payment benchmark that is based on the higher of the contracted in-network rates or a percentage of the Medicare payment. **Regulations mandating what must be paid for non-network services based on average or median billed charges increase the cost of health insurance and consumer out-of-pocket costs and further create a financial incentive for hospital-based physicians and freestanding ERs to remain out-of-network. Using billed charges as a standard clearly encourages artificial inflation of medical bills and puts consumers at greater risk for balance billing.**

Out-of-Network Balance Billing Protections

Even with stringent consumer and provider protections, because out-of-network providers have no limits on the amounts they can bill, a consumer can still receive a "balance bill" that is above the usual or customary charges (out-of-network payment) covered by the plan. When this happens, there are limited consumer protections that allow some consumers to request mediation, a process that effectively removes the consumer from the dispute and allows physicians and insurers to come to a resolution. Physicians may not attempt to collect balance billing amounts from patient enrollees once they have received notice that mediation has been requested. An individual may request mediation of a non-network balance bill if all of the following are met:

- The member has coverage through a fully-insured (not self-funded) PPO or EPO plan, or the State ERS plan.
- The medical service was provided by a non-network hospital-based physician in an in-network hospital.
- The "balance bill" amount owed to the physician is more than $500.
- The consumer was not notified of projected costs, or the amount billed to the consumer exceeds the projected amount.

Health plans are responsible for informing consumers of the potential of balance billing by hospitals and non-network facility-based physicians.

HMO and EPO plans do not provide benefits for non-network providers except in areas where a network provider is not reasonably available or in emergency care situations. Although not specified in the Insurance Code, TDI enforces "hold harmless" protections against balance billing in those scenarios for EPO and HMO plan enrollees. This means that the health plan pays the non-network provider's full billed charges upon receipt of the claim; or if it pays a lower covered amount, it must pay the billed charge or a negotiated amount to the non-network provider upon notice that the provider has balance billed the enrollee.

Out-of-Network Transparency Requirements:

Health plans are required to inform consumers about network and non-network status and payment.

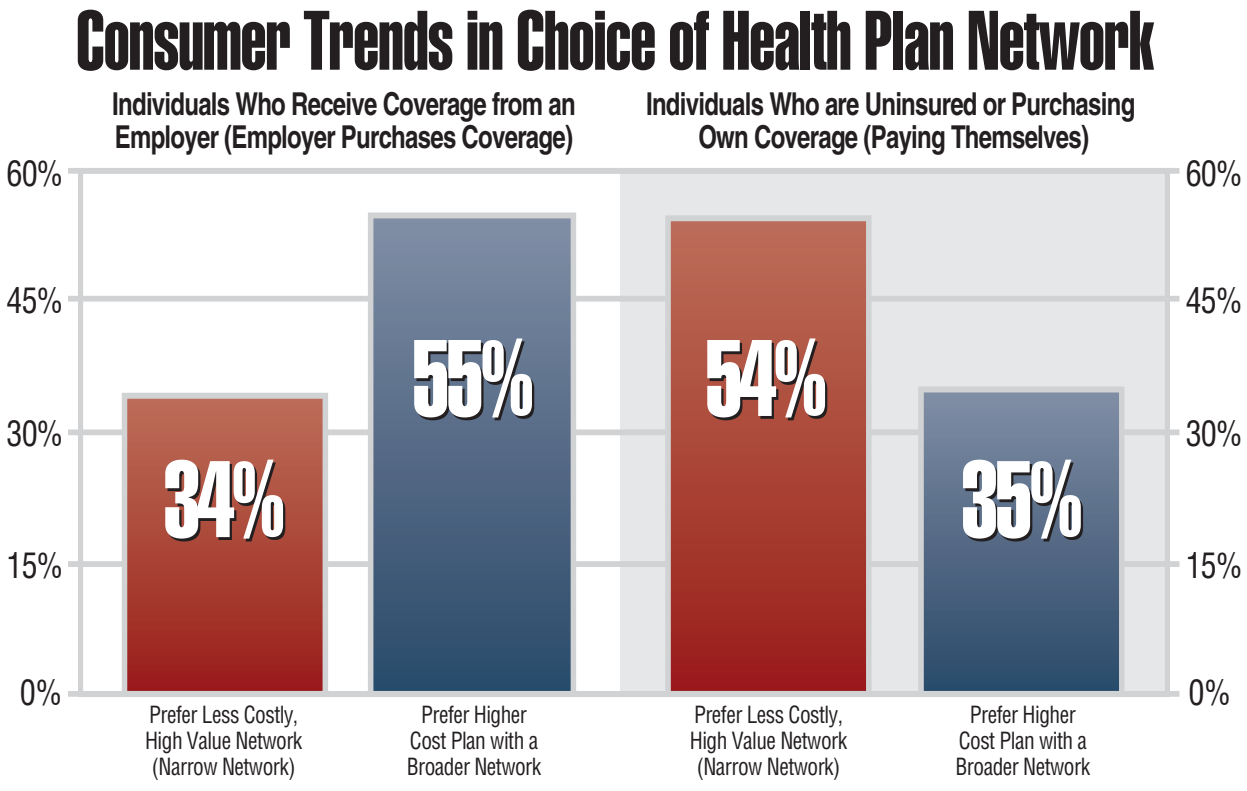
- Within 10 days of a request, health plans must provide consumers with estimates of payments including any deductibles, copays, co-insurance, or other costs.
- Health plans must report reimbursement rates, billed charges, contracted rates (for in-network providers) and "allowed amounts" (their usual or customary charge calculations for non-network providers) to TDI.
- Health plans' provider directories and web sites must clearly identify network hospitals in which facility-based physicians are not in the network.
- Health plans must provide written notice to consumers that (1) a physician providing services in a network facility may not be in the network, and (2) the physician may bill the patient directly for the amount the health plan does not pay (included on: enrollment and renewal materials; in the consumer's Explanation of Benefits, or EOB; and "conspicuously displayed" on the plan's web site).
- Health plan EOBs issued to consumers must identify when the health plan has paid a non-network physician and include a notice that a complaint about the health plan's payment to the non-network physician may be filed with TDI.

Consumer Trends in Choice of Health Plan Networks

A recent Kaiser poll found that the uninsured and consumers who purchase individual coverage for themselves are more likely to prefer less costly, narrow network plans over more expensive plans with broader networks (54 percent versus 35 percent). Those who are currently getting their insurance through an employer (who is protecting them from the cost of coverage) have the opposite preference: 55 percent prefer a more expensive plan with a broader network, while 34 percent would rather have a less expensive narrow network plan.[1]

The use of high-value networks or narrow networks typically results in noticeable reductions in premium costs compared to plans using broader networks. National research firm Milliman found that premiums are 5 to 20 percent lower in high-value networks.[2] A McKinsey report indicated that health coverage with broad hospital networks had high premiums with a median premium increase of 26 percent over plans with leaner networks. What does this mean financially for consumers? For a premium that is in the range of $300 to $350 for one person, this can mean savings of $60 a month or $720 a year for a high-value network plan. For a family, these savings are even more substantial.

Broad networks are available to roughly 90 percent of consumers, and smaller networks are available to 92 percent. (Source: McKinsey)



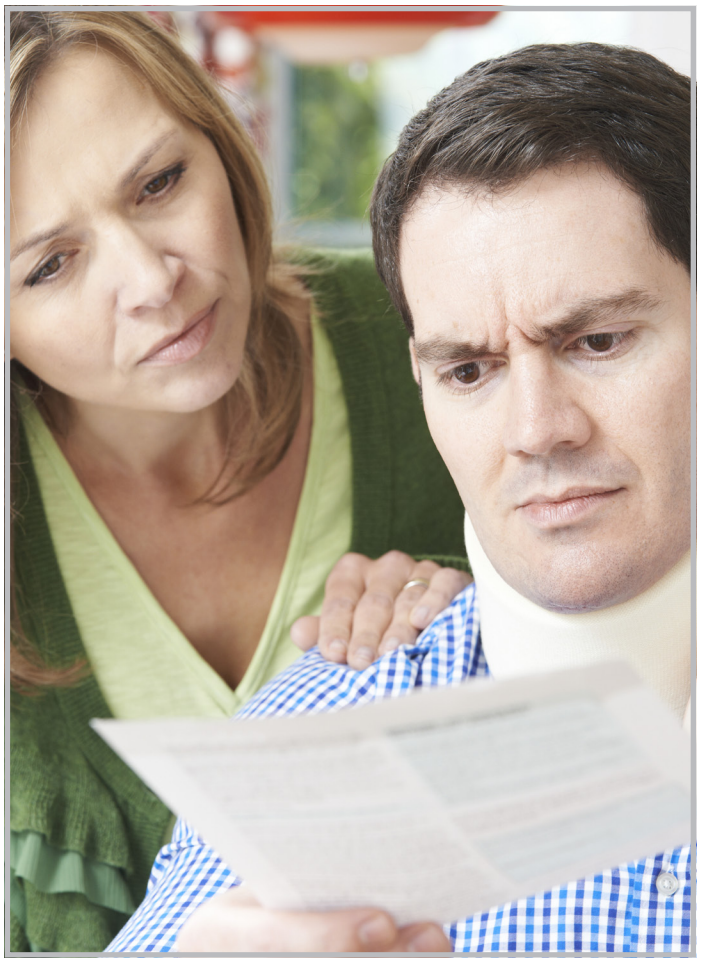
Source: Kaiser Health Poll, February 2014

Keeping Health Insurance Affordable

Acknowledging that one size does not fit all, health plans provide a wide array of plan choices that are designed to meet each individual's health needs and financial situation. Despite efforts to hold down premiums, research shows that premiums track directly with underlying health care costs, including the prices of various medical treatments and prescription drugs, which have been consistently trending upwards and can vary widely even within the same market. Achieving affordable health coverage is contingent upon lowering overall health care costs, a priority that is best served by moving away from a fee-for-service model that incentivizes volume of care to one that rewards quality and value.

Health plans have been at the forefront of health-system delivery and payment reforms that hold promise in reducing costs, while also improving efficiency and enhancing quality of care and patient outcomes. The use of high-value provider networks is one of the tools used by health plans to reduce costs and provide incentives for high-quality and cost-effective care for consumers. By identifying providers and facilities that consistently meet quality and safety metrics and are more efficient relative to their peers, health plans create networks that ensure consumers are getting the most out of their health care dollars.

Texas health plans operate under some of the most stringent network adequacy standards in the country. While regulations are necessary and exist to protect consumers and providers, when they become overly prescriptive, they can hinder innovation and increase the cost of premiums for consumers and employers.



Recommendations for a Competitive Health Insurance Market:

- Ensure that network adequacy and provider contracting standards are flexible and not overly prescriptive and rigid. They should not financially incentivize providers to be out-of-network or require plans to accept any willing providers.
- Allow flexibility for health plans to coordinate with contracted network providers to implement alternative payment and delivery system reforms to meet patient needs.
- Encourage health plans' innovative models of health care delivery and payment that can provide the building blocks necessary for lasting improvements in health care quality and measurable reductions in cost growth.
- Allow health plans and non-network providers to negotiate market-appropriate reimbursement rates through mediation rather than mandating reimbursement rates that may not be suitable for all services or geographies; expand consumer mediation options for balance billing.
- Expand transparency by all providers regarding network status, quality outcomes and pricing to reduce consumer confusion and foster a competitive health care market that will reduce problems like increased costs and balance billing of consumers.

[1]Kaiser Health Tracking Poll: February 2014, www.kff.org
[2]Milliman; High-Value Healthcare Provider Networks (July 2014)

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