House Insurance Committee Hearing
June 1, 2016

Texas Department of Insurance

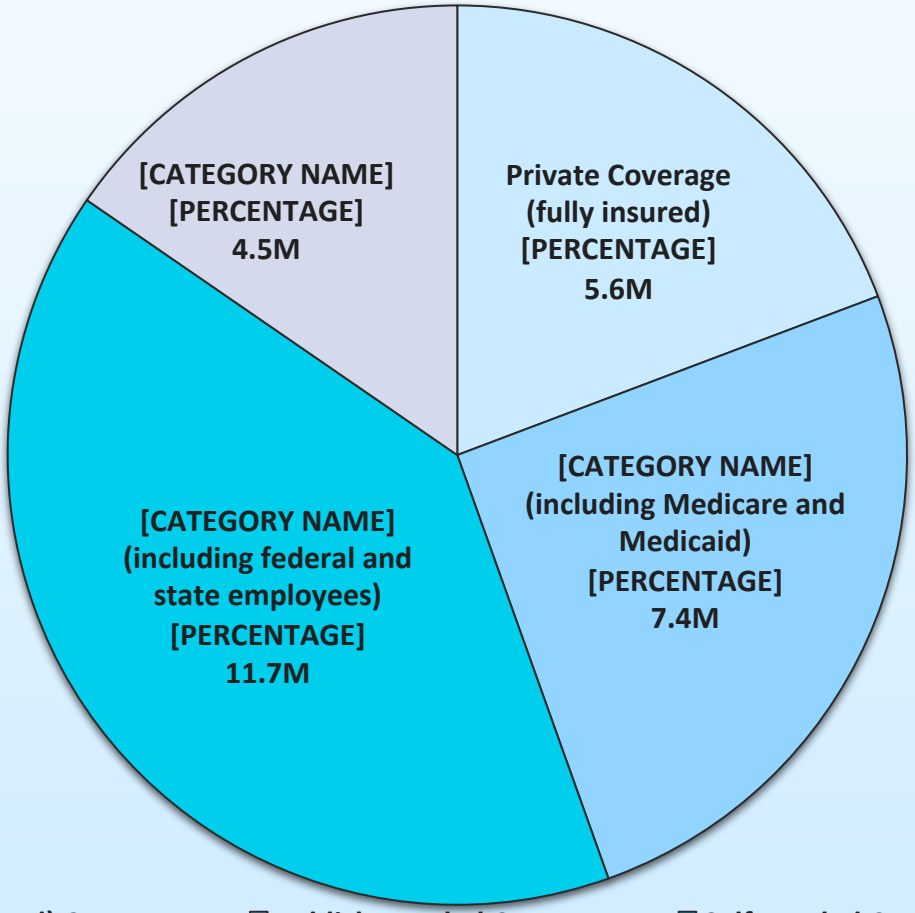
2016

Balance Billing Protections

- Transparency Requirements
- Payment Standards
- Mediation
- Network Adequacy Standards

The Texas Department of Insurance (TDI) Regulates Fully Insured Coverage

2014 Texas Coverage Estimates[1]



1 Note that some individuals have multiple coverages.

Transparency Requirements

Insurers (non-Health Maintenance Organizations (HMOs)) must:

- use language in policies that:
  - is readable and understandable;
  - discloses how reimbursements of non-preferred providers will be determined and the insured's financial responsibilities;
- if usual and customary charges are used, discloses:
  - the source of the data;
  - how the data is used in determining reimbursements; and
  - the existence of any reduction that will be applied; and
- if anything other than full billed charges is used:
  - discloses the possibility of balance billing;
  - provides a description of the payment methodology; and
  - provides a method for consumers to obtain a real-time estimate of how much a non-preferred provider will be paid.

Transparency Requirements

Insurers must use provider directories that are:

- updated at least every month;
- identify hospitals that facilitate the use of preferred providers;
- identify all in-network, facility-based physicians at network facilities and specifically identify facilities without any contracts with different types of facility-based physicians; and
- identify, for each contracted hospital, the percent of claims filed by out of network physicians, broken down by specialty.

Transparency Requirements

Insurers must provide consumers:

- notices of specified rights;
- notice of substantial decreases in the availability of facility-based physicians at contracted hospitals; and
- annual detailed notices regarding any network inadequacies.

Payment Standards

Payments to non-preferred providers must be calculated pursuant to an appropriate methodology that:

- if based upon usual and customary charges, then must be based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;
- if based on claims data, then must be based on sufficient data;
- is updated no less than once per year;
- does not use data that is more than three years old; and
- is consistent with nationally recognized and generally accepted bundling edits and logic.

Payment Standards

Payments to non-preferred providers must be calculated pursuant to an appropriate methodology that takes into account emergency, inadequate network, and inaccurate provider directory situations by:

- paying those claims, at a minimum, based on the usual or customary charge, less any coinsurance, copayment, or deductible;
- paying those claims at the in-network coinsurance percentage; and
- crediting any out-of-pocket amounts paid to the non-preferred provider above the allowed amount toward the insured's deductible and annual out-of-pocket maximum.

Mediation

- HB 2256 created a mediation process for balance billing issues in 2009.
- TDI began accepting mediation requests in 2010 and has seen a gradual increase over time as more consumers and providers become aware of the program.
- The scope of the statute is limited to balance bills by facility-based non-preferred physicians incurred at preferred (in-network) facilities.
- In 2015, SB 481 lowered the dollar threshold to balance bills of more than $500 (not including applicable coinsurance, copays, or deductibles) and added assistant surgeons.
- Most mediation requests are settled informally prior to actual mediation.

Mediation Requests

	2009	2010	2011	2012	2013	2014	2015
Total Number Received	5	14	21	7	146	893	1,062
Total Referred to SOAH (State Office of Administrative Hearings)	0	0	0	0	3	126	82

Network Adequacy
Health Maintenance Organizations (HMOs)

An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and

(2) 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers.

HMO Access Plans

If any covered health care service or a participating physician and provider is not available to an enrollee, the HMO must submit an access plan to the department for approval. The access plan must include:

- the geographic area in which services are not available, and for each area, the reason or reasons that covered health care services cannot be made available;
- a map, with key and scale, which identifies the areas that are inadequate;
- the HMO's plan for making covered health care services available in each area identified; and the procedures to be followed by the HMO to assure health care services are made available and accessible to enrollees, and any plans of the HMO for attempting to develop an HMO network in the future.

Network Adequacy
Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) Benefit Plans

The network must be sufficient in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area.

The network must provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:

(1) 30 miles in non rural areas and 60 miles in rural areas for primary care and general hospital care; and

(2) 75 miles for specialty care and specialty hospitals.

PPO and EPO Waiver Requests

An insurer may apply for a waiver from one or more of the network adequacy requirements if the insurer demonstrates that providers or physicians necessary for an adequate local market network:

(1) are not available to contract; or

(2) have refused to contract with the insurer on any terms or on terms that are reasonable.

PPO and EPO Waiver Requests

The waiver request must include:

- A list of the providers or physicians within the relevant service area that the insurer attempted to contract with;
- A description of how and when the insurer last contacted each provider or physician and a description of any reason each provider or physician gave for refusing to contract with the insurer;
- Steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary; and
- If no providers or physicians are available within the service area, the insurer's request for waiver must state this fact;

PPO and EPO Waiver Requests

The waiver request must include (continued from slide 15):

- At the same time an insurer files a request for waiver, it must file a local market access plan;
- An insurer seeking a waiver must also submit a copy of the request to any provider or physician named in the waiver request at the same time the insurer files the request with TDI;
- If TDI grants a waiver, TDI will post information on their website relevant to the grant of a waiver the name of the preferred provider benefit plan for which the request is granted; the insurer offering the plan; and the affected service area; and
- An insurer may apply for renewal of a waiver annually.

PPO and EPO Access Plans

An access plan must include for each service area:

- The geographic area within the service area, including which types of providers that are not available;
- A map, with key and scale, that identifies the geographic areas;
- The reason(s) that the preferred provider network does not meet the adequacy requirements;
- Procedures that the insurer will utilize to assist insureds in obtaining medically necessary services when no preferred provider is reasonably available, including procedures to coordinate care to limit the likelihood of balance billing; and procedures detailing how out-of-network benefit claims will be handled when no preferred or otherwise contracted provider is available.

Annual Network Adequacy Reports

Annual Network Adequacy Reports:

- Due April 1st every year
- Timeliness and accuracy of reporting increasing
- Reminder notices
- Audits of reported adequacy
- On going education efforts
- Proof of adequacy now being requested

Network Adequacy/Balance Billing Scenarios

- An enrollee has a planned surgical procedure scheduled at a participating facility, however, the hospital based providers are not on the enrollee's plan.

  Resulting Issue: network adequacy and balance billing issues.

- An enrollee, after consulting their current provider directory, has a planned surgical procedure at a facility, however, the facility and hospital based providers are not on the enrollee's plan.

  Resulting Issue: network adequacy, transparency, and balance billing issues.

- An enrollee chooses a participating facility from the provider directory, based on the information reflecting hospital based providers "contracted" with enrollee's plan.

  Resulting Issue: transparency and balance billing issues.

- An enrollee chooses to have a planned surgical procedure at a non-participating facility. None of the hospital based providers are participating in the enrollee's health plan.

  Resulting Issue: possible balance billing.

- An enrollee has an emergency health issue and is taken to the emergency room of an non-participating facility.

  Resulting Issue: possible balance billing.