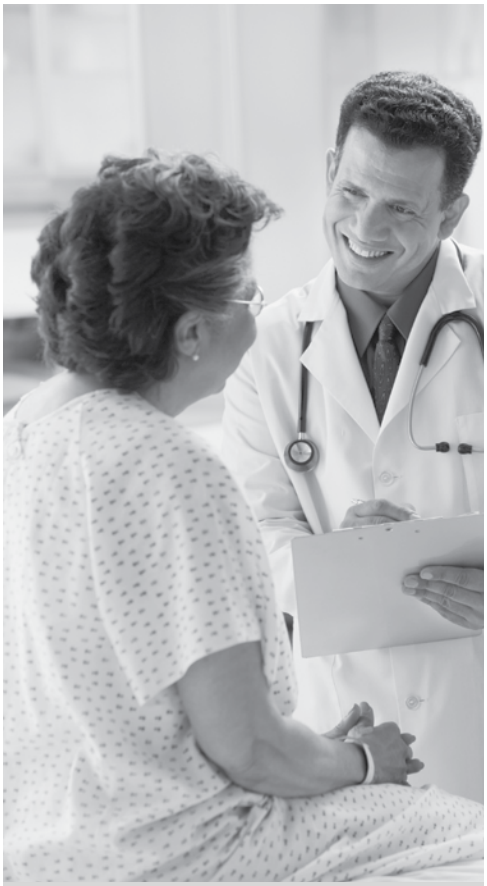
SUPPORT
SB 1257 by Sen. Kip Averitt



Texas physicians are dedicated to making the process more transparent, and ensuring that employers and employees — our patients — can see exactly how insurance companies are using these premium dollars.

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Health Insurance Code of Conduct Act of 2009

Skyrocketing Health Insurance Costs Affect All Texans

For many employers and their employees, yearly health insurance premium increases are unsustainable. No one feels this challenge more acutely than your local neighborhood businesses, such as family-owned restaurants, auto mechanic shops, and physician practices. All are trying to provide affordable health insurance coverage for their employees because it's the right thing to do. But in these uncertain economic times, affording health insurance is becoming more difficult. According to the U.S. Census Bureau and the Texas Department of Insurance (TDI), only 52 percent of Texans have coverage through their employer. For small businesses — the bulk of Texas employers — the number is even worse: 34 percent. In fact, Texas ranks last in the nation for employer-sponsored insurance.

So Where Are the Premium Dollars Going?

Texans pay more money each year for health insurance but receive less coverage in return. Patients are now paying more money out of their own pocket for their health care, and paying more for health coverage. Over the past decade, insurance companies have decreased their cost by increasing premiums and offering products with much larger deductibles, copays, and coinsurance.

While insurance premiums are increasing and patients are paying greater out-of-pocket costs, these companies also are ratcheting down physician payments. At the same time, the cost to run a physician practice has increased more than 30 percent. This is due to inflation and the ever-more complex paperwork burdens placed on them by health insurers. To compound matters, payments from Medicaid and Medicare have not kept pace with general inflation or physicians' operating costs.

What Should Be Done?

The time has come for Texas to implement solutions so that employers and patients can see exactly how their health insurance premium dollars are being spent.

Make Insurance Companies Accountable for Their Marketplace Decisions

Texas needs a health care system that allows all patients to receive the care they need when they need it. Removing barriers to affordable health coverage is critical.

To get there, legislators should enact a code of conduct that curtails skyrocketing health insurance premiums, brings more transparency to the business operations and coverage designs of this multibillion-dollar industry, and holds health insurance companies accountable for the promises they make to the Texans who pay their premiums.

The Texas Medical Association is asking legislators to support the Health Insurance Code of Conduct Act of 2009. This law would ensure transparency and accountability in the way health insurance companies conduct business and better protect patients from questionable insurance tactics that result in loss of coverage and increased out-of-pocket costs.

"Without accountability, insurers will continue to maintain pricing practices that lead to higher premiums and greater numbers of employers, employees, and individuals unable to purchase affordable coverage."

— *Susanne Madden*
CEO Verden Group,
closing testimony before
Texas Senate State Affairs
Committee on May 21, 2008

1. Transparency and Accountability in Health Insurance Cancellation and Rescission

Health insurer tactic: When patients incur high medical bills, health insurance companies increasingly are cancelling policies unilaterally, a practice called "rescission." Insurers pore over the patients' health information for evidence that the patients did not disclose their entire medical history to the insurance company on their insurance application. If an error or omission is found, no matter how insignificant, the insurance company rescinds the policy rather than continue to pay the patient's medical bills. What is worse, the insurer then attempts to reclaim all previous payments it made on the patient's behalf to doctors, hospitals, and other health care providers.

Patient impact: No health insurance when health care coverage is needed most. Patients also are stuck with additional medical expenses for prior payments the insurer revoked. Recently, only after a Waxahachie woman appealed to her congressman was her insurance coverage reinstated. The company said she did not check "acne" on her application, so it denied her treatment for breast cancer and revoked her coverage.

Code of Conduct solution: Require insurers to notify patients that rescission of their policy is under consideration prior to the actual cancellation. This will allow patients to contest the decision if desired and help prevent their policy from being revoked inappropriately.

2. Transparency and Accountability in the Calculation of Premium Quotes

Health insurer tactic: Insurance quotes are developed in a black box. Small employers and individuals have little or no understanding of how or why their health insurance premium quote increased from the prior year.

Patient impact: Paying more each year for unsubstantiated premium increases. At renewal, when small employers ask the broker, agent, or insurance company how their premium was spent, they often are told the information is not available, or they receive incomplete information. Recently Harris County Medical Society, a small, nonprofit business in Houston, experienced an unexplained double-digit increase in its premium quote with no understandable basis provided by the insurer that warranted the increase.

Code of Conduct solution: Allow Texas' small businesses to challenge insurance premium quotes, and have insurers provide information to justify a premium increase. If a small-employer premium increases more than 20 percent from the prior year, the employer can ask the Office of Public Insurance Counsel (OPIC) to assist with an appeal to the TDI commissioner.

3. Transparency and Accountability in the Calculation of the Medical Loss Ratio

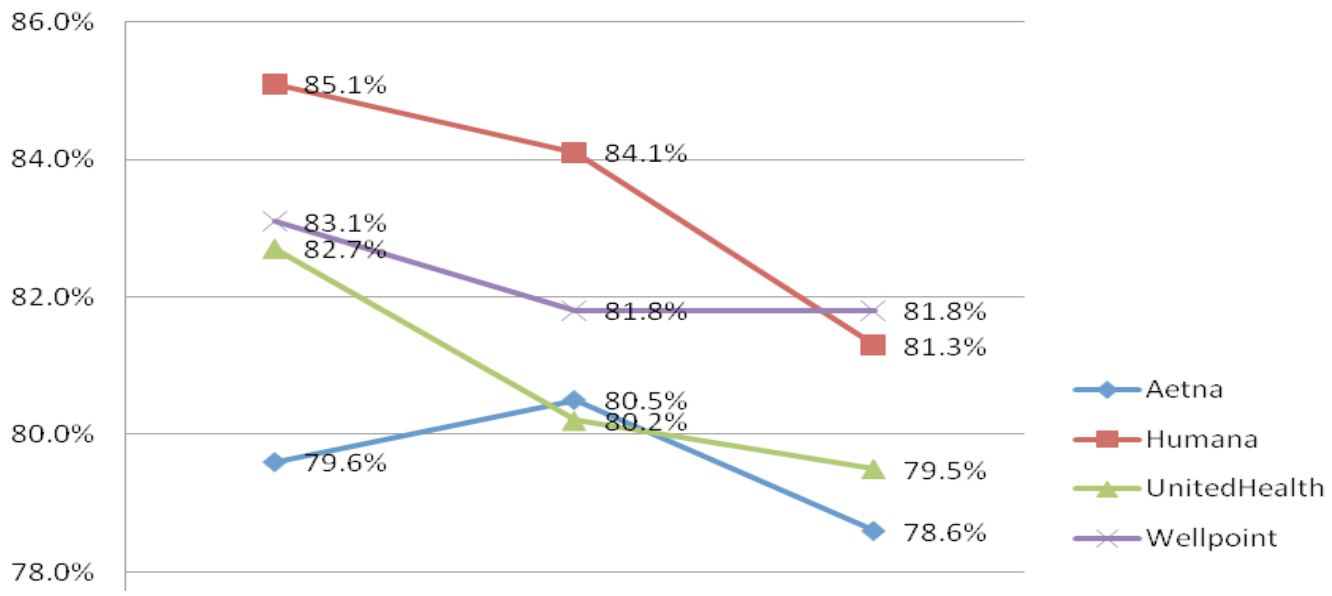
Health insurer tactic: Health insurer profits are expressed as part of the industry's term "medical loss ratio." The medical loss ratio is the percentage of premium dollars spent on payments to physicians, hospitals, and other health care providers for health care services rendered. The amount of premium dollars left over often translates into administrative expenses that include health insurer profits. Simply stated, insurers can maximize their profits by keeping the amount of the premium dollar they spend on the patient's health care to a minimum.

Patient impact: Employers and employees are spending more money on health insurance each year but have no idea exactly where their health insurance premium dollars are going. Are they going toward their health care costs or to the insurer's bottom line?

Code of Conduct solution: Provide a standardized definition and reporting formula for "medical loss ratio" that permits purchasers to compare performance. It also gives employers and employees the information needed to evaluate the insurer's use of their premium dollar before the policy is up for renewal.

We can see that the profit margin comes not only from increasing premiums but also by lowering the medical loss ratios spent on health care each year.

Medical Loss Ratios Q1-Q3, 2007



Using the figures in the chart, let's look at UnitedHealth Group to see what its medical cost ratio (MCR) savings might add up to be. Aggregated over three quarters, its MCR added up to a combined decline of 3.2 percent. Based on SEC filings, UnitedHealth Group reported premiums totaling $16,984,000,000 for those same three quarters. If we simply calculate what saving 3.2 percent of those premiums represents, we get a total of $543,488,000. That is, a 3.2-percent decline in MCR over nine months translates to more than a half-billion dollars in savings to UnitedHealth Group's bottom line.

"Consumers complain that they pay a great deal for health insurance, but question the value in return, as insurers deny coverage, delay payment, and deceive them. All too often, health insurers play a game of deny, delay, and deceive, and consumers pay the price."

— *State of New York, Office of the Attorney General,* Health Care Report: The Consumer Reimbursement System Is Code Blue

4. Transparency and Accountability in Physician Rankings

Health insurer tactic: All major health insurance companies in Texas use some form of physician ranking or tiering of their networks. They market these networks to employers and patients as "quality" enhancements or "high-performance" networks. In reality, the rankings are based almost exclusively on claims data and cost. They rarely include any review of the quality of care the patient receives. Repeatedly, physicians find numerous inaccuracies in the data. Health insurance companies also post these rankings publicly on their Web sites prior to giving physicians any opportunity to verify the accuracy of the information and correct any mistakes made by the insurer.

Patient impact: Employers and patients are being deceived about the availability and quality of the physicians in the health plans' networks, suffer disruption in longstanding patient-physician relationships, and have limited access to certain types of specialists.

Code of Conduct solution: Require health insurance companies to use scientifically valid criteria to evaluate physicians' performance and disclose those criteria in advance. Physicians need the opportunity to review their data and appeal their ranking before this information is made public.

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