Texas Medical Association

Physicians Caring for Texans

Surprise Billing/Network Adequacy Solutions

Texans Don't Understand Insurance Terms

On March 9, 2016, Rice University's Baker Institute for Public Policy and the Episcopal Health Foundation (EHF) issued a report (http://bit.ly/1TdUSkR) that found:

Of the five health insurance terms relating to costs, 25 percent of all adult Texans who were surveyed — both insured and uninsured — said they lacked confidence in understanding the concepts of 'premium,' 'deductible' and 'copayment.' More than 35 percent of Texans said they didn't understand 'maximum out-of-pocket expenses,' and 45 percent didn't understand 'coinsurance.' In addition, 30 percent of Texans said they lacked confidence in understanding the terms 'provider network' and 'covered services.'

The mediation process in Texas is working. However, some specific actions need to take place well before the patient/insured begins to access or receive any health care services. Below are TMA's suggestions for legislative solutions.

1. Increased network adequacy oversight.

There must be mandatory, increased state agency oversight of the adequacy of all of an insurer's networks, especially for the insurers that patients often bring to mediation. Prompt pay penalties the Texas Department of Insurance used to fund the now-abolished Texas Health Insurance Risk Pool could be used to hire additional personnel devoted to network oversight.

2. Expand the current mediation process.

Mediation currently pertains only to certain claims for services provided by out-of-network, hospital-based physicians at in-network hospitals. In the context of the current law's application to PPO plans and certain state employee health benefit plans, mediation for out-of-network claims should be expanded to apply to claims for:

- Services provided by an out-of-network physician or health care professional at an in-network hospital;
- Emergency care provided by an out-of-network physician or health care professional at a hospital or freestanding emergency medical care facility/department, regardless of the network status of the hospital or freestanding facility/department;
- Emergency services provided by an out-of-network hospital or freestanding emergency medical care facility/department; and
- Out-of-network ambulance services.

3. Maintain the current mediation threshold and the patient's role in the mediation process.

The mediation threshold of a $500 balance after copayments, deductibles, and coinsurance should be maintained. Patients must continue to be the initiators of Texas' mediation process for the surprise bills they receive that meet the $500 out-of-network threshold. The patient should remain the connection for any discussion that takes place about what the insurer paid for the out-of-network services that resulted in the patient receiving a surprise bill.

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4. **Require insurers to tell their customers about the network status of physicians and others who may bill for services as part of any prior authorized procedure.**

   For elective services prior-authorized by the insurer at an in-network hospital or ambulatory surgical center, insurers should be required to inform patients in advance about: (1) the network status of the facility-based physicians and others who may participate in their care and bill for services, and (2) the amount of their out-of-pocket responsibility for any out-of-network services and the bill(s) they may receive.

   Additionally, insurers should be required to update their network directories more frequently to provide the patient the most accurate and up-to-date information.

5. **Physicians should use a standard disclosure form to remind patients about which physicians and providers may be involved in their care and how to contact them.**

   This standard disclosure form should be provided for all planned procedures, surgeries, or deliveries. The form should instruct patients on how they may contact those physicians and providers for information regarding their network participation status and the patients' personal financial responsibility for services they may provide. The form should include disclaimers to notify the patient that: (1) unanticipated complications or events may require other physicians or providers to provide services, and (2) if those physicians or providers do not participate in the health plan's network, the patient may be billed for amounts not paid by the health plan.

6. **Improve insurance literacy at the point of purchase.**

   Insurers, brokers, and agents should be required to articulate clearly, at the time of purchase, the nuances of the care products they are selling. They need to educate consumers on the basic limitations of the plans they are buying, such as any applicable deductibles or network limitations. This will ensure consumers are educated about their out-of-pocket responsibilities both in and out of network and, as a result, reduce their surprise when they actually seek services. The statutory continuing education requirements for brokers and agents should be amended to include a health literacy component. Health literacy instruction that is specific to guiding consumers in understanding health care coverage could be recognized as a viable credit towards continuing education requirements.

7. **Require insurance companies to prominently display a network warning notice to consumers.**

   Insurers offering PPO products should be required to include a clear and conspicuous notice regarding the implications of using or receiving services from an out-of-network physician or provider and the potential for balance billing. This notice should be available and accessible on their websites to both potential customers and current enrollees. It should be included in all policy documents and provider directories. The notice should clearly state how payments to out-of-network physicians and providers are calculated and that patients may be required to pay more than their usual deductible, coinsurance, or copayment amounts.

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