



Physicians Caring for Texans

Texas Medical Association Testimony: Senate Committee on Business and Commerce

Monitoring Charge 2:

Monitor the implementation of legislation addressed by the Senate Committee on Business and Commerce during the 84th Legislature, Regular Session and make recommendations for any legislation needed to improve, enhance, and/or complete implementation. Specifically, monitor the following: (2) Implementation of legislation intended to further protect consumers from the balance billing process.

May 4, 2016

Presented by: Gerald Ray Callas, MD

Good morning, Chairman Hancock and members of the committee. My name is Dr. Ray Callas. I am a practicing anesthesiologist with Anesthesia Associates in Beaumont. I have clinical privileges at several inpatient and outpatient facilities in the Beaumont area. My physician group has been caring for patients since 1952. I currently serve as chair for the Texas Medical Association's (TMA's) Council on Legislation, and I am here today representing TMA and its more than 49,000 physicians and medical student members. I would like to thank Chairman Hancock and the committee for the opportunity to present the physician perspective on Senate Bill 481 and possible enhancements to reduce the likelihood of "surprise" billing.

Background

Texas' mediation process established under then-Rep. Kelly Hancock's House Bill 2256 has been successful because it has held insurers, facility-based physicians, and yes, even patients, accountable since 2009.

In 2015, TMA supported Senator Hancock's Senate Bill 481 as amended in the House, which made eligible for mediation balances for certain out-of-network services performed at in-network hospitals of \$500 or greater after the patient had met his or her copay, coinsurance, and deductible. We also supported the addition of the assistant surgeon to the definition of "facility-based physicians" because surgical patients should know if another physician will be involved in their care and be able to plan for that additional out-of-pocket expense as necessary.

Physicians agree: No one likes to be surprised by unexpected out-of-pocket costs. Unfortunately, whether an individual buys a health plan through a broker or an agent, or through the exchange, or receives insurance through an employer, there was never any guarantee that all services rendered would be provided by in-network physicians or providers, or even at in-network hospitals or other types of facilities. The consumer may have expected or assumed that would be the case, but that's not how products allowed to be sold in the market today are designed.

The Affordable Care Act brought both challenging administrative changes and new decisions to make. Texas physicians were glad to have more of their patients covered, but that new coverage compounds and highlights the many administrative challenges that physicians and their staff experience with our patients already covered by individual and commercial group policies.

The "Surprise" Happens Because Consumers Don't Understand Basic Policy Terms or Limitations

Unfortunately, yet understandably, the mechanics of health insurance coverage are not widely understood by the public. Consumers, who are eventually my patients and who are your constituents, sometimes are surprised by

the receipt of or amount of a bill for healthcare services, because either they weren't informed about or didn't understand the limitations of the policy they purchased. A recent Rice University report confirms this.

On March 9, 2016, the Rice University's Baker Institute for Public Policy and the Episcopal Health Foundation (EHF) issued a report (<https://www.sciencedaily.com/releases/2016/03/160309094345.htm>.) 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.'

On March 24, 2016, another report (<https://www.sciencedaily.com/releases/2016/03/160324143224.htm>) issued by this same group found:

Texans who bought their own health insurance also had more difficulty understanding how to use their health plans. *More than half (51 percent) said that they lacked confidence to understand how much it would cost to go to care providers outside of their plan's network.* Nearly half (46 percent) said they didn't understand what counts as preventive services, many of which are covered by health plans at no additional cost. *(Emphasis added)*

At the very least, before the consumer takes the plunge and makes any coverage purchase, and well before the consumer seeks services, shouldn't there be an expectation that whoever is selling or providing coverage will tell the consumer the following:

- How an HMO versus a PPO versus an EPO product works;
- How to use a provider network in general, including the impact of the overlay of a "limited or narrow" network;
- The importance of adequate provider networks in general when looking at the various coverage options for the consumer's health care situation — it's not just about the premium amount;
- The effect of in-network versus out-of-network use on out-of-pocket payments, such as deductibles, copays and coinsurance;
- How the above terms impact the consumer's out-of-pocket responsibility; and
- The likelihood that the consumer will incur other expenses when actually accessing services. These will be in the form of copays and variable deductibles and coinsurances for in-network and out-of-network services, which the consumer will have to pay to the physician, hospital, or other health care provider.

Brokers and agents often have the first contact with potential purchasers of health care coverage who have never been insured before. It would benefit consumers to require brokers and agents to capitalize on those "teachable moments" presented when the consumer, their client, is in front of them to enhance the consumer's understanding of what he or she is purchasing and to counsel the consumer accordingly.

TMA Recommendations:

Health literacy instruction that is specific to guiding consumers in understanding health care coverage could be recognized as a viable credit towards agent and broker continuing education requirements. The statutory

continuing education requirements for brokers and agents should be amended to include a health literacy component.

Require insurers to provide brokers and agents with the tools they need to more clearly articulate, at the time of purchase, the nuances of the health care products they are selling. This will ensure that consumers are educated about their out-of-pocket responsibilities both in and out of network and, as a result, lessen their surprise when they actually seek services.

These recommendations are important because the ACA has brought a new challenge: a marketplace that requires brokers and agents to discuss complex benefit designs and choices with a clientele with whom they have not interfaced historically, because these consumers have never been insured. The recommendations would allow consumers, and employers and their employees to benefit from these early discussions with the health insurance broker or agent.

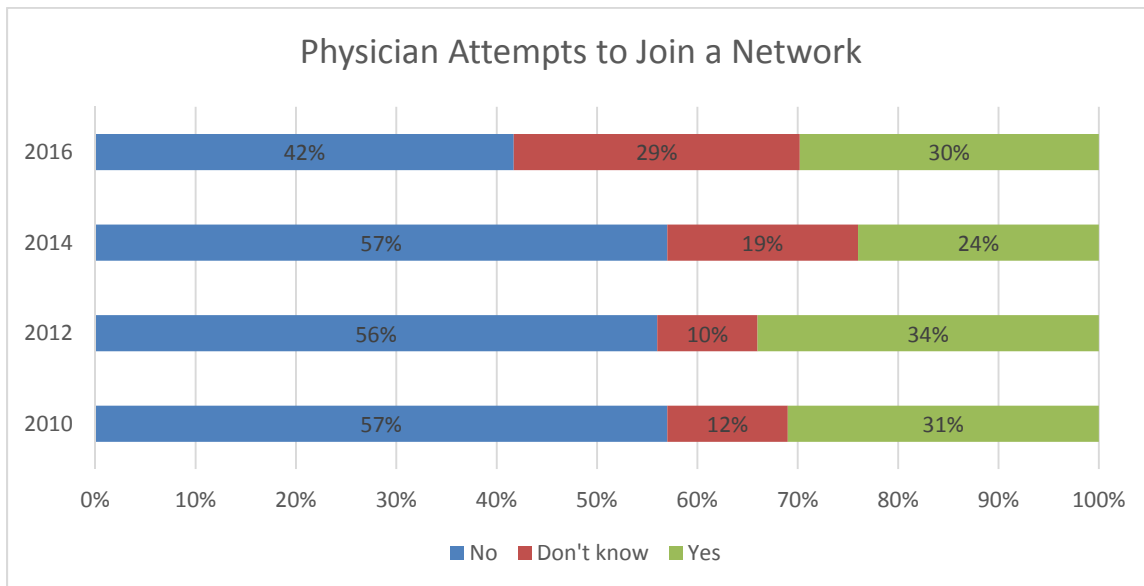
Narrow Networks Impact Access to Care and Increase the Likelihood of Greater Out-of-Pocket Costs

Often health plans will advertise they have certain physicians, hospitals, and other health care providers contracted to provide services, making it appear they have very robust networks from which a patient may access health care. This can be misleading to consumers because sometimes the provider network advertised is applicable only to certain products or services. Patients who purchase coverage with a low premium rate may find out later about the “limited” or “narrow network” they are required to use and end up paying higher out-of-pocket costs if they fail to use the narrow network.

Patients often do not realize the impact of this limitation until they have been treated and are recuperating at home. Health plans like to blame physicians’ unwillingness to contract as the reason for the unavailability of a particular specialty in a network, thus creating the balance billing scenarios we hear about. The TMA 2016 Physician Survey results tell a different story. See the charts below.

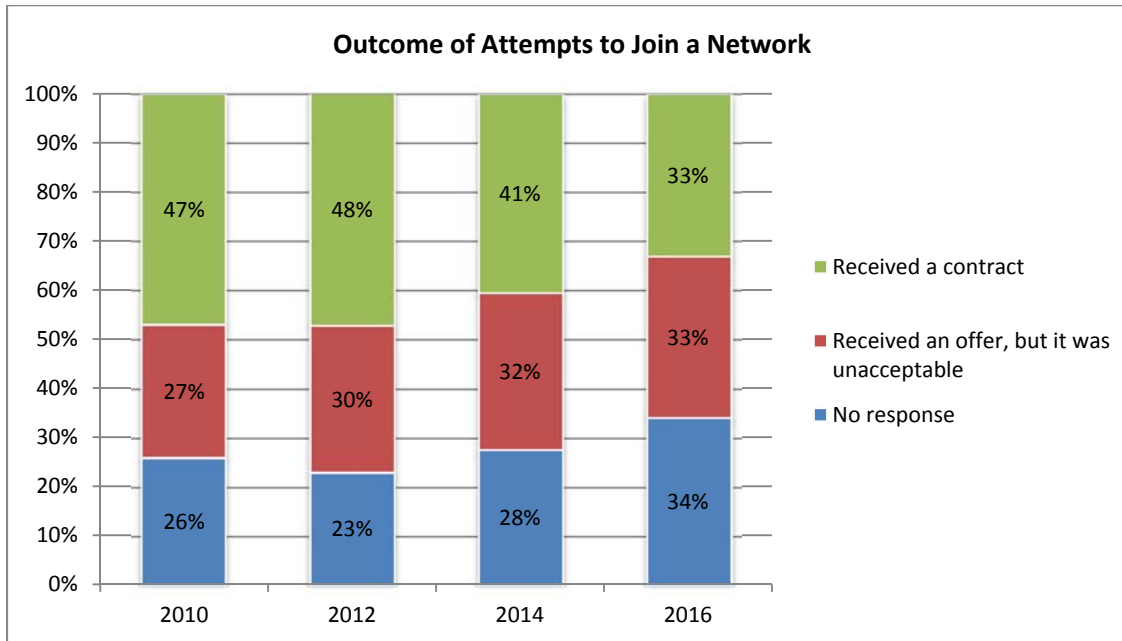
Physician Attempts to Join a Network

Thirty percent of physicians approached a plan with which they were not contracted in an attempt to join their network in the past two years (up from 24 percent in 2014).



Outcome of Attempt to Join a Network

Among physicians who approached a plan in an attempt to join their network, 67 percent of physicians received no response or an unacceptable offer from the plan (up from 60 percent in 2014).



Even though “narrow networks” are a market strategy totally contrived and controlled by the health plans as a cost-saving mechanism, the health plans like to blame the physicians for the increased prevalence of surprise/balance billing. This is simply not the case.

I have a personal story to share with you regarding contract activity, or should I say inactivity, between one major payer in Beaumont and my physician group. Anesthesia Associates is contracted with four of the five major payers in the Beaumont and southeast Texas area. This shows my group is willing to negotiate. When my services are valued at pretty consistent, negotiated amounts across the four payers, the result is that we are in-network for all four of them. More importantly, this example shows that it is *solely* this fifth health plan, and not my group, that is creating an out-of-network situation and causing its enrollees to pay more out of pocket in the form of higher out-of-network deductibles and greater out-of-network coinsurance amounts. Plus, this fifth health plan creates a balance billing scenario every time I provide anesthesia for its enrollees. We continue to reach out to this payer with little or no movement or response on its end.

TMA Recommendation: Require insurers offering PPO products 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 on their websites, applicable policies and provider directories. The notice should clearly state:

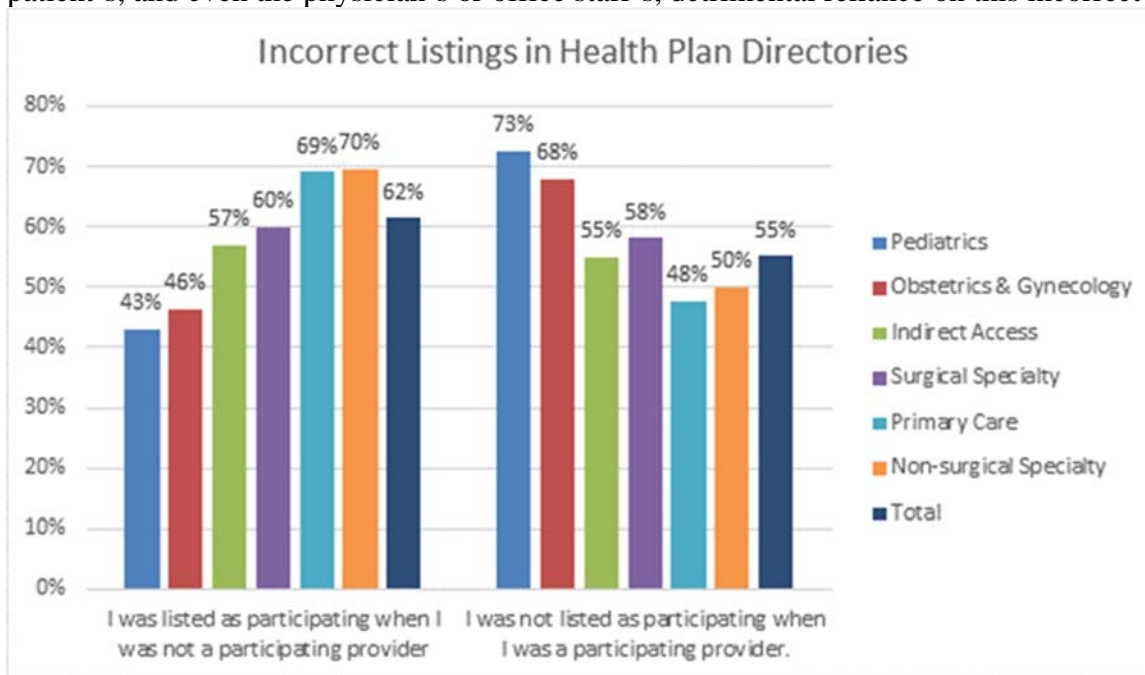
WARNING: Limited benefits will be paid when nonparticipating providers are used. Please be aware that when you receive services from a nonparticipating provider for a covered nonemergency or emergency service, our payments to providers are not based upon the amount the provider charges. Your payment responsibility for the out-of-network service generally will be calculated according to your policy’s coinsurance percentage for out-of-network services and based on the maximum allowable amount we decide to pay. Nonparticipating providers may bill you for any difference in the amount left unpaid. You may be required to pay more than your usual deductible, coinsurance, or copayment amounts.

This type of notice is important. Oftentimes when consumers purchase policies over the internet, they may never have the opportunity to talk with a live person such as a broker or agent, who could educate them about how the coverage they purchased will work when they access or receive services out-of-network. It should always be prominently placed on the cover of any applicable policies and provider network directories, as well as publicly accessible to both potential and current enrollees on the insurer’s website where products that have different in-network and out-of-network benefits are sold.

TMA Recommendation: For elective services prior-authorized by the insurer at an in-network or out-of-network facility or ambulatory surgical center, require the insurer to contact and inform the patient before the scheduled date of the service about the network status of the facility-based physicians and others who may participate in their care and bill for services. The insurer at that time should provide information to the patient about the amount of the patient’s out-of-pocket responsibility for any applicable out-of-network services identified by the insurer.

This insurer requirement is important because it is another opportunity not only to lessen the “surprise” about the lack of network providers, but also to make the consumer aware of the potential for additional out-of-pocket costs if the patient’s coverage uses narrow networks. Because insurers contend the maximum allowable amounts they pay for out-of-network services are proprietary, those amounts are unavailable to out-of-network physicians and oftentimes not readily available even to their policyholders.

Another reason the insurer should bear this responsibility is that indirect-access physicians (a.k.a. facility-based physicians, as noted by the green bar in the graph below) are found to be listed incorrectly by the insurers more than 50 percent of the time according to TMA’s 2015 survey. This incorrect portrayal of the network by the health plan increases the likelihood of the patient receiving a surprise bill due to the patient’s, and even the physician’s or office staff’s, detrimental reliance on this incorrect information.



TMA Board of Trustee Task Force on Balance Billing: How Physicians Can Lessen the Surprise

Previous legislative activity here in Texas, in other states, and at the federal level, coupled with press and social media coverage surrounding surprise bills, prompted the TMA Board of Trustees to establish a task force on balance billing last fall. It instructed the task force to research patient and physician perceptions about balance

billing and to recommend any necessary changes to TMA policy. The TMA board appointed to the task force 11 physician members, some of whom had been impacted by balance billing legislation and others who had not been impacted directly.

To guide its decision making, for potential TMA legislative policy recommendations, the task force adopted the following principles:

- The recommendations must provide for a unified voice and message across medicine.
- The recommendations must continue to protect the right of physicians to bill for out-of-network services.
- The recommendations must align with the best interests of our patients.
- The recommendations must address the behaviors of insurers that finance health care and apply to all practitioners involved in patient care, not merely the medical profession alone.

TMA staff were directed to undertake consumer and market research as well visit with our various county medical societies around the state to obtain feedback from physician leaders. The task force also directed TMA staff to solicit input from Texas consumers and to conduct market research about “surprise bills.” TMA hired an outside company to conduct consumer focus groups throughout October. TMA made good strides in our consumer and market research efforts, coupled with direct input from medical society leaders.

All focus group participants were insured. The participants were employer-insured, self-insured, or covered by the insurance exchange marketplace. The participants were balanced by political identification (Democrat, Republican, or independent). Balance by gender, age, and race also was considered.

The focus group feedback indicated that insured Texans:

1. Understand that health care costs are their responsibility and want to handle these costs correctly.
2. Can’t get enough information from any one source to ensure they know upfront what they are getting themselves into regarding medical care.
3. Operate under the presumption that if their hospital, clinic, or emergency department is “in network,” the professionals who work there and treat them are in network as well. This presumption is dispelled only when they receive a bill from a physician who was not fully paid.
4. Can’t avoid balance bills, even when they know about the possibility of receiving one.

The House of Delegates, TMA’s policymaking body, just this past weekend instructed TMA to advocate legislatively for the following:

TMA Recommendations for Expansion of the Current Mediation Process:

- ***The current mediation threshold of a \$500 balance after copayments, deductibles, and coinsurance should be maintained.***
- ***In addition to facility-based physicians, mediation should be expanded to apply to all out-of-network physicians, health care professionals, and vendors regardless of the network status of the facility.***
- ***Mediation also should apply to any out-of-network hospital, outpatient hospital, ambulatory surgical center, free-standing emergency facility or department and ground ambulance services.***
- ***Texas patients must continue to be the initiators of Texas’ mediation process for the surprise/balance billings they receive that meet the \$500 threshold for out-of-network bills. The patient should remain the nexus for any discussion that takes place about what the insurer paid and what the physician billed for the out-of-network service(s) the patient received.***

TMA Recommendation for a Standard Disclosure Form for Patients (see attached example):
Physicians and providers should be required to use a standard form to disclose to patients the identity of other physicians or non-physician practitioners typically practicing in the facility where the planned services, surgical procedure or labor and delivery will occur.

- *The form should instruct patients on how they may contact those physicians and non-physician practitioners for further information regarding their network participation and to inquire about the patients' personal financial responsibility for those services.*
- *The form should include disclaimers to notify the patient that unanticipated complications or events may require other physicians or non-physician practitioners to provide services.*

TMA Recommendation for Increased Network Adequacy Oversight by the Texas Department of Insurance:
There must be mandatory, increased state agency oversight of the adequacy of insurer networks, especially for insurers often brought to mediation by patients. Prompt pay penalties the Texas Department of Insurance (TDI) used to fund the now-abolished Texas Health Insurance Risk Pool could be used to hire additional TDI regulatory personnel devoted to network oversight.

Closing

Thank you, Mr. Chairman, for the opportunity to provide the committee with our insight and recommendations. I will be happy to entertain any questions.

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Draft Sample of Physician/Provider/IProcedure Network Disclosure Form

Patient Name: _____

DOB: __/__/_____

Plan Name: _____

Plan ID #: _____

Treating Physician/Surgeon: _____

Procedure Date: _____ Phone: _____

ICD-10/Diagnoses: _____

CPT/Procedure Code(s): _____

The information below is to disclose to you that there are many physicians and health care providers who may be involved in your care for the scheduled treatment/test/surgical procedure noted above. Even if you have some form of insurance coverage, it is possible that not all the physicians and health care providers will be in your insurer/HMO network. We have provided the names and contact numbers of the facility, physicians and other health care providers this office **typically** utilizes to provide services during this scheduled treatment/test/surgical procedure. Please note, however, that the list below may not necessarily reflect all the physicians and health care providers who may be involved in your care. Additionally, despite this office's best efforts to disclose other participants in your care, other circumstances beyond this office's control (e.g., facility scheduling or other physician staff changes by the facility or other factors associated with your care) may result in modifications or additions to the list below.

Prior to this treatment/test/surgical procedure, it is important that you or a family member (or another authorized representative on your behalf) contact the facility and each of those physicians and/or health care providers checked below about their network status. This is because your specific type of coverage AND each physician's and provider's network status will affect the amount you will owe out of pocket for that physician/provider's specific service(s) such as a copay, deductible or co-insurance. They can inform you whether or not you may be responsible for any other balances not paid or covered by your insurer/HMO.

Always contact your insurer/HMO for information regarding your specific health plan's benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that impact your liability for payment for the scheduled treatment/test/surgical procedure and/or implant/prosthesis.

Facility Name: _____ Phone: _____

Assistant Surgeon: _____ Phone: _____

Anesthesiology Group: _____ Phone: _____

Neonatology Group: _____ Phone: _____

Pathology Group: _____ Phone: _____

Radiology Group: _____ Phone: _____

Misc. Practitioner: _____ Phone: _____

Misc. Vendor: _____ Phone: _____

Implant/Prosthesis: _____ Phone: _____

Physician/Physician Representative

Date

Patient/Patient Representative