



Physicians Caring for Texans

Putting the Pieces Together

Network Inadequacy and Unfair Discrimination in Insurance

“We can’t verify that (the insurance companies) do, indeed, have an adequate network, and that’s concerning,’ acknowledged ... [the] director of the insurance department’s managed care quality assurance office.”

— *Houston Chronicle*, Dec. 2014

VISION: To improve the health of all Texans.

MISSION: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

Executive Summary

Health insurance is merely a form of financing health care. Insurance companies are financial institutions that collect premiums in exchange for a promise to make payments when certain losses occur, such as an expense for medical care.

Unfair Discrimination and Preferred Provider Plans

Prior to 1986, Preferred Provider Benefit Plans, commonly known as PPOs or PPBPs, were prohibited in Texas, as they ran afoul of the prohibitions against offering an unjust policy, engaging in misrepresentation, deceiving the public, and engaging in unfair discrimination. Unfair discrimination in insurance occurs when an insured person pays the same premium as others, has the same risk of loss (illness in health insurance) as others, suffers the same losses as others, but receives a different benefit. The Texas State Board of Insurance legalized PPOs/PPBPs through a 1986 regulation that the Texas Legislature ratified by enacting a 1997 insurance law on preferred provider benefit plans. The Code contains a safe harbor for PPOs/PPBPs against claims of unfair discrimination or unjust policy terms.

The health insurance many consumers purchase are managed care products. PPOs/PPBPs are managed care products that offer a basic level of coverage to consumers applicable in all circumstances (what many call an “out-of-network benefit”), while also offering a different level of coverage when care is provided by a preferred provider. Consumers have an expectation that they will receive the highest level of benefit for all services at an in-network hospital. However, the PPO/PPBP benefit they have purchased **is a limited form of financing** and unfairly discriminates in that an insured person will have lower coverage based on who is available in a hospital to treat the patient.

The consumer discovers the limitations of PPO/PPBP coverage (the unfair discrimination) when he or she receives a bill for services that has gone unpaid by the insurer. The bill surprises consumers as they expected complete coverage and settlement by the insurer. Physicians can be contracted with a health insurer, only to be excluded by that insurer from some of the plans it offers. So a physician may be in-network for some consumers and out-of-network for others — all at the health insurer’s option. Managed care claims in PPOs/PPBPs are not settled at the actual cost, but at an allowed amount. This causes confusion over the amount left unpaid in addition to the confusion over why payment by the consumer is necessary at all.

With the introduction of narrow networks, it is likely more consumers will face greater personal financial exposure.

Unfortunately, when Texas consumers most need coverage, especially in emergencies, they are discovering the limitation of the coverage they have purchased. Simply, in those situations, the consumer is no longer satisfied with the savings insurance network products offer when that means greater financial burden in emergencies. Yet, despite network shortcomings, consumers do not want to be left without the choice of managed care health plans that offer network benefits.

The Texas Department of Insurance (TDI) generally enforces the Insurance Code through a complaint-based methodology. However, though there are regulations in place to facilitate TDI monitoring of network adequacy (specifically a requirement to file a network adequacy report annually), insurers fail to comply with those regulations. According to reports, only **25 of the 140 preferred provider plans offered in Texas submitted network adequacy reports by December of 2014 — eight months after the compliance deadline.**

Texas consumers deserve to have a functioning insurance regulatory framework. The Office of Public Insurance Counsel (OPIC) may be able to play a useful role in that framework. OPIC currently issues HMO report cards, but is not authorized to do so for PPO/PPBP insurance coverage. OPIC should be able to issue reports on network adequacy as well as file complaints with TDI on network issues and violations.

HMOs Have Consumer Protections in Place — For Now

Through regulation, TDI has ensured that HMOs must ensure consumers are held harmless and pay an amount sufficient to prevent a request for payment of emergency services from a non-network provider or physician.

In addition, according to TDI, in non-emergency circumstances there is also a “statutory directive to HMOs to ‘fully’ reimburse the providers needed to fill network gaps at an agreed upon or usual and customary rate.”¹ To fully reimburse “can require payment of full-billed charges.” Unfortunately, TDI has released an informal draft regulation that seeks to *weaken* these protections in the HMO marketplace to the detriment of consumers.

Policy Solutions

(1) Allow Consumers to Purchase the Product They Demand. Require all state-regulated insurers offering preferred provider benefit plans *to offer*, for purchase, additional coverage to settle claims for labor and delivery and emergency care, and any subsequent admissions to the hospital at the preferred level of coverage. This should apply to individual, small group, and large group coverage.

(2) Safeguard Old and New Consumer Protections. Ensure Texas consumers continue to receive the advantage of TDI HMO emergency care/inadequate network protections and the new PPO/PPBP rules that credits all payments for out-of-network care in emergencies (or where the network is inadequate) to a consumer’s in-network deductible and out-of-pocket maximum. Also, the PPO/PPBP regulations, which provide guidance to insurers that usual and customary charges must be used to settle claims where the network is inadequate, should also remain unchanged.

(3) Authorize OPIC to Monitor Networks. TDI is a complaint-based agency. However, network adequacy requires ongoing monitoring. The Office of Public Insurance Counsel is charged with acting on behalf of consumers *in certain circumstances*. OPIC’s authority should be augmented to permit OPIC to monitor network adequacy in the HMO *and* PPO/PPBP lines of insurance business. OPIC should be granted the ability to file complaints with TDI upon the office’s discovery of an inadequate network or other violation of network adequacy laws or regulations. OPIC currently issues HMO report cards for use by consumers. These report cards should contain an evaluation of HMO network adequacy. OPIC should be charged with the duty to develop and issue report cards for PPO/PPBP plans that include an evaluation of those networks.

(4) Authorize OPIC to Intervene in Access Plan Filings and Network Adequacy Waiver Requests. TDI currently permits HMO and PPO/PPBP products to file an access plan in circumstances where the insurer’s network is inadequate. Carriers are able to request waivers from certain network requirements. Require HMOs and insurers to provide a copy of any such filings to OPIC, and permit, at the Counsel’s discretion, the office to oppose TDI approval of these filings.

(5) Stabilize Networks. The network directories that consumers depend upon are notoriously inaccurate. Stabilize the networks the insurers market by restricting without cause terminations of physicians and providers. Prohibit insurers from exercising without cause termination clauses within the first six calendar months and last three calendar months of each year. Authorize OPIC to file complaints with TDI on inaccurate HMO and PPO/PPBP directories.

¹ <http://www.tdi.texas.gov/reports/documents/finalbie07.pdf>.

What Is Health Insurance? OR What Am I Really Buying?

The Affordable Care Act (ACA) is having profound effects on the health insurance benefits available to consumers, and the changes are still coming as fast as ever. However, one thing that has not changed is the nature of insurance — which is to offer financing when an unexpected catastrophe hits. So, when a consumer buys health insurance, he or she is not buying health care or access to health care, he or she is purchasing financing and payment when illness strikes. Health insurance isn't a guarantee that the consumer will not have to pay anything out of pocket for health care (there are no guarantees in life), it is only a promise that the insurance company will consider the possibility it might pay something under certain circumstances described in the insurance contract (the policy). A way to think about what insurance actually offers is to think about what a credit card offers. **Both a credit card and insurance are a form of financing purchases!** The credit card company does not provide the products you buy and a health insurance company does not provide the health care you need. They both finance your ability to fund those purchases.

Managed Care and Health Insurance: *There Is a Difference!*

Before the arrival of managed care, if you bought health insurance financing, you bought indemnity coverage and could receive the same level of financing for care provided by any physician or hospital you chose. That was a time when insurance paid a fixed amount or fixed percentage for any health care expenses, and you paid the remaining amount. Those days are long gone. Managed care came along and introduced the concept of copayments and networks, which limits the financing available to consumers when they don't use a network provider. Managed care plan design does not guarantee a consumer will always be treated by a network provider; however, the plan's benefit design allows for different levels of financing for coverage of in-network and out-of-network services. (See the section below for explanations of “indemnity insurance” and “managed care.”)

What Is a Hospital? OR Isn't a Hospital a Single Business?

A hospital is an institution established to provide facilities for the care and recovery of patients. “For most of the nineteenth century, however, only the socially marginal, poor, or isolated received medical care in institutions in the United States. When middle- or upper-class persons fell ill, their families nursed them at home.”² As medical care increased in complexity (along with a need for sterile environments), a gradual shift toward the provision of certain intensive medical services increasingly took place in hospitals.³

Medical services are provided by professionals, typically physicians. The hospital is the place of service. In other words, physicians practice medicine through a profession. A hospital provides a campus under one roof that supports the practice of medicine and offers a safe, optimal environment for the provision of patient care. Hospitals, physicians, and other health care practitioners are separate in function and responsibilities.

Think of a hospital like a retail mall. A mall is a place of service that offers a “campus under one roof” for selling products and services by many different vendors or stores.

Insurance and Credit Cards — Hospitals and Malls

Now that we have commonplace comparisons of what insurance and hospitals are, consider the following analogy:

A customer will enter with the intention of using a particular brand of credit card. Within the mall, there are many merchants who offer products and services to meet particular needs. A customer might be surprised to learn that some of the merchants at the mall do not accept the customer's credit card. If the customer wants to purchase a particular product from that store, the customer will have to pay the full

² Wall, PhD, RN, FAAN, Barbra Mann. [History of Hospitals](http://www.nursing.upenn.edu/nhhc/Pages/History%20of%20Hospitals.aspx), www.nursing.upenn.edu/nhhc/Pages/History%20of%20Hospitals.aspx.

³ Id.

amount asked out-of-pocket. Just because you shop at a single location doesn't mean everyone at the location will accept the same financing. **That is true in a hospital as well. Some of the physicians, technicians, the hospital itself, and other providers may accept differing insurance financing.** So, an insurance company may have network arrangements with many practitioners in a hospital, but not *all* of the practitioners. Just like a mall may have *some* retailers who don't accept particular credit cards.

Health Insurance Premiums

A health insurance premium is the monthly amount an insurance company charges for health insurance coverage. Insurance is a contract by which the insurer undertakes to indemnify another party (the insured person) against risk of loss or liability arising from a specified occurrence.⁴

Before the introduction of managed care, most health insurance was indemnity insurance.

Indemnity Health Insurance provided coverage (meaning the insurance company would pay) for actual losses due to health-related expenses from illness or injury. The key term in this simple definition is “actual losses.” The coverage in traditional indemnity insurance coverage was calculated on the actual loss suffered by the insured person without regard to who provided the service — that is not the case today in managed care coverage.

The following offers a good description of indemnity coverage. (The reference to “you” refers to the consumer.)

Reimbursement: Actual Charges. Under this type of plan, the insurer will reimburse you for the actual cost of specified procedures or services, regardless of how much that cost might be.

Reimbursement: Percentage of Actual Charges. Under this type of plan, the insurer pays a percentage of the actual charges for covered procedures and services, regardless of how much those procedures and services cost. A common reimbursement percentage is 80 percent. This has the same effect as a 20-percent copayment.

Indemnity. Under this type of plan, the insurer pays a specified amount per day for a specified maximum number of days. Although your reimbursement amount does not depend on the actual cost of your care, your reimbursement will never exceed your expenses.⁵

A premium paid to a company offering a managed care plan is not a payment to protect against actual losses. A managed care plan is much more limited.

Managed Care is a system of coverage whereby covered persons agree to visit certain physicians and hospitals for which a managing company monitors the cost of treatment.⁶ Managed care companies have contracts with physicians, health care providers, and medical facilities to provide care for members at reduced costs. How much of your care the plan will pay for depends on managed care companies' rules.⁷ In other words, the managed care coverage persons are purchasing (including coverage in the health insurance marketplace) is not intended to cover “actual losses”; it is intended only to reduce (by some amount) the cost to covered persons.

Even the legal definition of “HMO” captures the distinction, as an HMO must offer a plan that “consists *in part* of providing for ... services on a prepaid basis *through insurance or otherwise*, as distinguished from indemnifying for the cost of health care services.”⁸

⁴ *Black's Law Dictionary*, eighth edition.

⁵ Indemnity Plans vs. Managed Care, <https://www.miller-miller.com/content/health/indemnity>.

⁶ CMS Data Navigator Glossary of Terms. www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf.

⁷ National Institutes of Health, Medline Plus. www.nlm.nih.gov/medlineplus/managedcare.html.

⁸ Texas Insurance Code, §843.002(12)(B). (emphasis added).

What Is an HMO?

An HMO is “a person who arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan.”⁹ A “person” can mean individuals or companies, but in this case it refers to companies. The catch in this type of plan is that the enrollee (a person covered in an HMO) must receive services only from physicians and providers in the HMO delivery network. (See below for a description of a network.)

In other words, HMOs work just like gym memberships. In a gym, members pay a monthly fee in exchange for the unlimited use of the exercise machines at that gym or other associated locations. There is no additional fee for use of the machines. In exchange for your monthly premium an HMO provides — pre-paid — the basic health care services you may need.

What Is a PPO or PPBP?

The acronym “PPO” or “PPBP,” for the purpose of this discussion, refers to **preferred provider benefit plans**. A preferred provider benefit plan is an actual insurance product. It is not “prepaid healthcare” like an HMO. The Texas Insurance Code defines a PPBP as a “benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.”¹⁰

Out-of-Network Benefits in PPBP

When one reads the definition of “PPO/PPBP” from the insurance code, you can see that these managed care plans are derived from indemnity plans. When a person buys PPO coverage, he or she is buying a “basic level of coverage” that is applicable **in every medical setting. There is no such thing as an out-of-network benefit — it’s a basic benefit!** In addition to the basic benefit, you receive a “level of coverage that is different” when you use a preferred provider. That is the “in-network” benefit. So, in Texas, when consumers buy PPO coverage, they are buying a basic level of coverage with an additional in-network benefit. It is the different level of coverage (an incentive to use preferred providers) that modifies the insurance product sufficiently to characterize it as managed care rather than “traditional” indemnity coverage.

Surprise Bill or Surprise Coverage

The PPO/PPBP basic level of benefits (those benefits that provide coverage even out of network) does not provide full coverage (as illustrated below in How Does a PPO Determine Coverage?). The consumer is surprised by the coverage/payment limitations in PPOs when it becomes apparent there is an outstanding bill for services that must still be paid by the consumer.

PPOs Were Once Arguably Illegal — Because They Impose “Unfair Discrimination”

Before 1986, a health insurance company in Texas could not offer a product for sale that would result in different levels of coverage based on who treated the patient. Such a policy **unfairly discriminates** in the coverage provided to patients. In other words, **the surprise that one may have lower coverage and may have to pay more when a service is provided by a non-contracting provider** was illegal. The product could not be sold because of the unfairness inherent in the insurance product. **Texas still generally prohibits unfair discrimination in insurance:**

Sec. 544.052. UNFAIR DISCRIMINATION. A person may not in any manner engage in unfair discrimination or permit unfair discrimination between individuals of the same class and of essentially the same hazard, including unfair discrimination in:

⁹ Texas Insurance Code §843.002(14).

¹⁰ Texas Insurance Code §1301.001(9).

- (1) the amount of premium, policy fees, or rates charged for a policy or contract of insurance;
- (2) the benefits payable under a policy or contract of insurance; or
- (3) any of the terms or conditions of a policy or contract of insurance.¹¹

When insured persons receive notice there is an outstanding bill not paid by the insurer, especially for service at an in-network hospital, **they are surprised by the unfair character of the coverage they have purchased.** When insured persons are concerned that they “didn’t know” they were receiving care out-of-network, they are expressing a concern that they “didn’t know” (or actually didn’t expect) they would have a higher financial exposure/different lower level of coverage within the hospital.

PPO/PPBP coverage is legal only because the long-since eliminated Texas State Board of Insurance adopted a regulation to permit the sale of these products. The board adopted preferred provider plan regulations in 1986, permitting health insurers to offer a different level of coverage when consumers use preferred providers. Prior to that time, an insurer offering differing levels of benefits was still subject to penalties for offering an unjust policy, engaging in misrepresentation, deceiving the public, and engaging in unfair discrimination.¹² However, the Texas State Board of Insurance, in an effort to permit the introduction of new insurance products, adopted regulations to allow for the existence of preferred provider benefit plans. **At the time, there was no statute, other than the rulemaking authority of the board, to permit PPOs/PPBPs.**

The board stated in its adoption order for the 1986 rules that, “These sections apply only to a plan that an insurer has provided through an insurance policy.” The purpose of the new preferred provider benefit plan regulations were “to provide consumers with an opportunity for different levels of coverage under terms of health insurance policies which maintain freedom of choice for the insured among health care providers and which . . . maintain protections for the insured against misrepresentation, deceptive practices, unjust treatment and unfair discrimination.” The board opined that the changes made to the final rule, after comments, resulted in “strengthening choices and protections for insureds.” More than a decade later, 1997 to be exact, the Texas Legislature ratified the board’s actions.¹³

If a Managed Care Plan Doesn’t Protect Against Actual Losses, How Does a PPO Determine Coverage?

When a person seeks medical care from a physician, the arrangement is between the doctor and the patient. The bill for services always belongs to the patient. In some cases, managed care companies have pre-negotiated payment rates for services, but not always, and that is when the limited financing under the non-network benefit can leave a patient with a balance to pay.

Why do patients receive a bill? Because they have received a service and care from a physician. Why do insurance companies leave their customers with bills to pay? Well, that is a more complicated answer and is a clever insurance company tactic.

Remember, your health insurance is just a method of financing — just like your credit card (except with insurance, you make your payments before you use it). Suppose a person goes to the grocery store and decides to pay with her credit

¹¹ In other words, it is illegal for an insured person to pay the same premium as others, have the same risk of illness (in health insurance) as others, suffer the same losses as others, but receive a different benefit. Yet, that is exactly what happens in PPO/PPBP “surprises”: Some services have the preferred coverage, others do not receive preferred coverage.

¹² See, generally, 11 TexReg 2810, adopting 28 Tex. Admin. Code §§3.3701-3.3705, to be effective July 1, 1986.

¹³ Acts 1997, 75th Legislature, ch. 1024, § 1, effective June 19, 1997.

card. This customer is \$100 from hitting her credit limit. When the customer attempts to purchase \$150 of groceries, the customer must pay the grocery store the remaining \$50 unpaid balance. If the customer wants to walk out of the store with the additional \$50 in groceries, she is going to have to pay out of pocket. If you want an increase in financing (your credit limit), you don't ask the grocer, you must ask the credit card company.

Let's use another analogy. Under your automobile insurance coverage agreement, you pay premiums every month to finance repairs to your car in the event you are in an accident. In addition, you have a deductible that you have to meet before the financing kicks in. Your auto insurer will then decide what it will pay toward repairs (the loss resulting from the accident), which impacts what you have to pay out of your own pocket. Automobile insurers also favor the use of "reconditioned" auto parts, but maybe you think you should receive new parts. Whatever the source of the disagreement between you and your auto insurer, if you are unhappy with how your auto insurer settled your repair claim (because you think it should have paid more), you complain to your insurer or department of insurance, not the body shop owner.

It is very similar with health insurance. When a patient has insurance and receives a bill for medical care under the non-network benefit, it is because the health plan determined what it was willing to pay for the out-of-network care (i.e., the credit limit in insurance) and left the rest for the patient to pay. So, when the patient receives \$150 in medical services out of network but the financing only pays for \$100, the remaining amount is for the patient to pay. If the patient thinks the insurer should pay more, then she should ask her insurer to pay more — just like you would ask your auto insurer to pay more in the previous example.

Managed care companies use either the agreed contract rate (for circumstances where a contract exists in-network) or an internally developed amount called the "allowable charge," which is then used to establish the amount the company will pay.

An "allowable charge" is the maximum amount a third party or an insurance company will reimburse a physician or provider for a specific service.¹⁴ It's the dollar amount a managed plan will pay to a provider and *consider* a charge for service as paid in full.¹⁵

Without regard to the actual loss (the charge) for a medical service, the allowable charge is the amount at which the company will *consider* its obligations to have been met.

This is how this sleight of hand of allowable charge works in limiting insurance company liability and causing covered persons to pay more:

Suppose your health insurance coverage for out-of-network services is based on a 70/30 coinsurance benefit design. Without understanding the difference between indemnity insurance and managed care, one might assume that a person would pay 30 percent of the amount billed for a medical service.

For example, when your physician files a \$1,000 claim to the health plan for an out-of-network service, your assumption is the health plan will pay \$700 and you will pay \$300 (30 percent). That might be true under a traditional indemnity plan, but it isn't true in managed care.

A managed care plan pays its percentage on the "allowable amount" for that particular medical service. The allowable amount can vary from company to company.

Settlement of the Claim — The Past

If five companies offer managed care plans that provide 70/30 coverage, each of those plans will actually pay much different amounts for services out of network because each company sets its own allowable amount. So, a person covered

¹⁴ United HealthOne Learning Center. www.goldenrule.com/glossary-terms/allowable-charge/.

¹⁵ United HealthOne Learning Center. www.goldenrule.com/glossary-terms/maximum-allowable/. (emphasis added).

Plan and Patient Share: 30% Out-of-Network Coinsurance, \$1,000 Charge

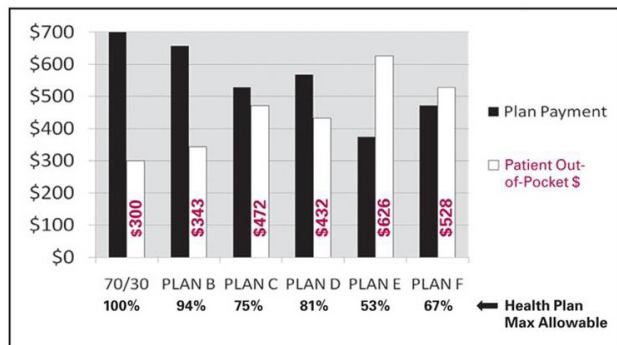


Fig. 5

Out-of-Network Coverage: 70/30 Coinsurance, \$1,000 Charge

What the Patient Thinks:

- Patient assumes his health plan will pay 70% of the charge: **\$700**
- Patient assumes his share is 30% of the billed charge: **\$300**

The Reality:

- Plan E determines the value of the service (i.e., the maximum allowable charge) should be no more than \$530. Plan E pays 70% of \$530: **\$374**
- Patient is responsible for the remainder of the \$1,000 charge: **\$626**

Source: Self Reported Health Plan Data for Senate Bill 1731 Advisory Committee on Network Adequacy

Fig. 4

under Plan E expects to pay 30 percent of the charge, or \$300. Instead, the patient will pay 63 percent of the charge, or \$626, for an out-of-network charge of \$1,000. This is because Plan E pays only \$374 of the patient's claim — and because the health plan based its 70 percent on its self-determined allowable amount, not a percentage of the physician's charge.

This is not an arbitrary number chosen for the purpose of this document; it was the actual average settlement amount an insurer reported to the Texas Department of Insurance in 2008. Six companies reported information to TDI, and the differing settlement averages are shown in the adjacent figures as to how they would affect patient claims.

Plan E reported that its maximum allowable amount for out-of-network services, on average, is 53 percent of actual charges. No other health plan reported limiting its maximum allowable to that degree. At the same time, if a person is lucky and happens to be covered under Plan B, that person would pay only \$343 for the same service because Plan B pays \$657, based on its maximum allowable amount of 94 percent.

TDI has — at least once — sanctioned an insurer for setting “allowable” amounts for non-contracted facilities at unreasonably low rates... ” and the “rates are unreasonably low in light of representations made by the company in its advertising and its policies... ”¹⁶ The company did not admit to wrongdoing, but nonetheless settled for \$3.9 million and agreed to modify its method of determining the “allowable” for certain facilities.

You may wonder what the new standard for allowable turned out to be after the TDI intervention. The policy was revised to say:

Allowable Amount means the maximum amount determined by [company] to be eligible for consideration of payment for a particular service, supply, or procedure. ... For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with [company] in Texas ... The Allowable Amount will be the lesser of the Provider's billed charges or the [company] Allowable Amount. The non-contracting Allowable Amount is developed using [company] network Allowable Amount data for similar Network Providers at a service level identified by standard contracting identification methods. The Allowable Amount for non-contracting Providers represents the average contract rate for Network Providers adjusted by a predetermined factor established by [company] and updated on a periodic basis. Such factor shall not be less than 75% and will be updated not less frequently than once every two years.

So, for persons covered under a policy with the language above, they now know for services out-of-network (including emergency services), the company's payment is **not based on your actual loss**, but is instead based on at least 75 percent of the company's average contract rate. Under no circumstances will the insurance company allowed amount ever be greater than 100 percent of the average contract payment. The covered person is responsible for all other payment.

¹⁶ TDI Order 08-0514.a

As the Plan and Patient Share chart in this report shows, the maximum allowable is not always based on the medical loss, and directly affects the patient's financial burden. Because the insurer determines the dollar amount that is multiplied by the "percentage level of reimbursement," the insurer substantially determines how much out-of-pocket expense the patient may face.

New Insurance Regulations on Claim Settlement – A New Future?

The Texas Department of Insurance has adopted regulations recently that seek to protect consumers from unfair claim settlement processes in PPO/PPBP plans. (HMOs have an older, more comprehensive set of regulations.) Under the TDI regulations, when services are rendered to an insured by a non-network physician or provider because a network physician or provider is not reasonably available to the consumer (which includes emergency care), the insurer must:

- Pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;
- Pay the claim at the preferred benefit coinsurance level; and
- In addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

Just How Important Is the New Texas Consumer Out-of-Network Credit Protection?

In the past, when you were billed by an out-of-network physician or provider for emergency care, **you did not receive any credit** for the balance (loss) you were left to pay that your insurer didn't cover. Today, under Texas regulation, if you submit proof to your insurer that you paid that balance amount to the out-of-network physician or provider, **your insurer is required to credit the balance amount you paid toward your in-network deductible and annual out-of-pocket maximum.** In essence, these out-of-network balances assist you in reaching your in-network deductibles and out-of-pocket maximums sooner rather than later, or never, in some cases.

The new protection is vitally important for Texas consumers. It doesn't settle the claim on the actual loss facing the consumer, but it potentially may offer greater protections in the future.

Why Wasn't I Informed That My Managed Care Plan Covers Only Allowable Amounts, Not the Actual Charges I May Have to Pay?

Actually, there may have been several attempts to inform you about the limitations of your coverage.

First, when a consumer shops for insurance, that person is provided a Summary of Benefits and Coverage (SBC). An SBC is a plain-language description of the plan you may be considering for purchase. Within the SBC is a description of the limits on your coverage in out-of-network circumstances. The sample SBC says:

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)

Also, one should note that in the SBC, there is no promise that in-network care is available in all circumstances for preferred provider products. That is not the only notice you may have received about the possibility having to pay for amounts left unpaid by insurance carriers.

Hospitals are required by Texas law to inform consumers that a physician or other health care provider who may provide services to the consumer while in the facility may not be a participating provider with the same insurers or third-party payers as the facility.

In addition to the SBC (required by federal law) above, health insurers have duties under state law to inform their customers — insured persons. Texas law requires an insurer to let consumers know that physicians or other health care practitioners may not be included in the health benefit plan's provider network even at a network hospital and that the practitioner may bill the enrollee for amounts not paid by the health benefit plan. The insurer has multiple opportunities to inform the consumer of this limitation in coverage (with issuance or renewal of the policy, evidence of coverage, EOBs), and is required to display this information on any health benefit plan website that a consumer is reasonably expected to access.

Physicians have obligations as well. As they provide the service without delay nor inquiry into ability to pay, physicians must inform patients/consumers that they may discuss payment plans with the physician. If the consumer substantially complies with the agreement, the physician may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the medical treatment.

Why Is the Surprise Over Coverage and Outstanding Bills Not a Problem for HMOs?

Because emergency care benefits and TDI regulations on inadequate networks for HMOs offer greater protection. TDI regulates HMO networks more closely, due to the fact there are no benefits available for non-network services. TDI interprets the HMO statute

to require that an HMO enrollee [must] not be responsible for payment of a balance bill. While different, the critical statutory similarity is that the prepaid nature of HMO coverage and the concept of pooling of risk requires that an HMO must hold harmless (except for scheduled expenses) its enrollees obtaining emergency care services. Any other interpretation could discourage HMO enrollee access to emergency care out-of-network, as enrollees fearful of financial harm might postpone necessary emergency care until they can return to their service area and network.¹⁷

In 2007, the Texas Legislature ordered TDI to study network adequacy. TDI's committee repeated its stance as follows:

[s]ince there is no benefit for out-of-network services, an HMO is required to hold the patient harmless so that there is no impediment for HMO enrollees to seek emergency care. While different, the critical statutory similarity is that the prepaid nature of the HMO coverage and the concept of pooling of risk require that an HMO must hold harmless its enrollees when obtaining emergency care services. Any other interpretation could discourage HMO enrollees from seeking out-of-network emergency care if they are concerned about the financial risk.¹⁸

In addition, according to TDI, in non-emergency circumstances, there is also a “statutory directive to HMOs to ‘fully’ reimburse the providers needed to fill network gaps at an agreed upon or usual and customary rate.”¹⁹ To fully reimburse “can require payment of full-billed charges.” The statute to which TDI refers is Texas Insurance Code §1271.055.²⁰ Unfortunately,

¹⁷ “Biennial Report of the Texas Department of Insurance to the 80th Legislature,” p. 11 (December 2006).

¹⁸ “Report of the Health Network Adequacy Advisory Committee, Senate Bill 1731, 80th Legislature, Regular Session,” p. 10 (January 2009). (emphasis added).

¹⁹ www.tdi.texas.gov/reports/documents/finalbie07.pdf.

²⁰ That section reads: Sec. 1271.055. OUT-OF-NETWORK SERVICES.

(a) An evidence of coverage must contain a provision regarding non-network physicians and providers in accordance with the requirements of this section.

(b) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider and within a reasonable period, shall:

(1) allow referral to a non-network physician or provider; and

(2) fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

(c) Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested.

TDI has released an informal draft regulation that seeks to *weaken* these protections in the HMO marketplace ... to the detriment of consumers.

This means under certain circumstances, such as emergencies or where the network is inadequate, HMOs currently must pay an amount sufficient to prevent a request for payment from a non-network provider or physician.

TDI has, in essence, prevented unfair discrimination in HMO products for emergency services and inadequate network circumstances through this interpretation.

TDI is now in the process of soliciting comments on an informal draft regulation that seeks to weaken the protections discussed above. TMA opposes, strenuously, any modification (in regulation or statute) to the hold harmless protection that the interpretation above provides.

How Does TDI Enforce HMO and PPO/PPBP Regulations?

Like any other state agency, TDI enforces the law and regulations through a complaint-based process. Some other aspects of insurance regulation are undertaken through a monitoring process, mainly financial regulation of insurers.

Still, TDI does require PPO/PPBP insurers to file a network adequacy report in April of every year. **Insurers typically have refused or failed to comply with this requirement.** The *Houston Chronicle* examined insurance company compliance with the filing requirement only to discover a majority of the industry did not report. The article stated:

New state regulations meant to protect Texans from unfair medical bills largely have been ignored by many health insurance companies, and state officials have done little about it, according to public records.

The new rules require insurance companies to submit reports to the Texas Department of Insurance detailing the adequacy of their health care networks.

According to insurance department records, however, reports for only 25 of the 140 preferred provider plans offered in Texas were submitted by an April 1 deadline. And after more than seven months in which regulators have not levied any sanctions, only three more providers have submitted reports.²¹

Even more troubling, “ ‘We can’t verify that (the insurance companies) do, indeed, have an adequate network, and that’s concerning,’ acknowledged Debra Diaz-Lara, director of the insurance department’s managed care quality assurance office.”²²

Consumers need active oversight and continuous monitoring of HMO and PPO/PPBP networks. The Office of Public Insurance Counsel is an independent agency that is to represent the interests of consumers, including small commercial insurance consumers. OPIC’s charge (and resources) may need to be broadened to complement the TDI complaint-based enforcement of network regulations. OPIC, in its just-issued HMO report card, stated the following:

The increase in [Basic Service HMO] complaints includes many administrative complaints such as delays in furnishing information to consumers, **failure to properly disclose provider networks**, failure to properly inform consumers of prescription drug coverage/copays/ limits, and **improperly expecting additional payment.**²³

²¹ Rosenthal, Brian. “Most insurance companies not complying with billing transparency law State can’t assess if the plans meet consumer needs; no penalties levied,” *Houston Chronicle*, Dec. 10, 2014.

²² Id.

²³ Office of Public Insurance Counsel. “Comparing Texas HMOs 2014,” p. 110.

What Is the Price of Medical Services?

A physician's price is his or her billed charge. Like any other small business the physician must ensure that his or her price is adequate to cover the cost to provide services including overhead costs and all labor costs in the practice. Furthermore, the price must be sufficient to cover all the costs of charity care and bad debt, and allow a reasonable return on the investment of the practice owners (just like any small business). Any price a physician may settle upon must not be the result of agreements with other physicians who are external to the practice, but instead must be his or her independent determination. (See Information and Internet Transparency Doesn't Eliminate Price Dispersion below.)

The billed charge is the amount the practice will collect from a patient for services absent an agreement (such as a managed care contract) or discount policy (if applicable) and is obtained through a cash payment and non-cash in-kind services (such as patient steerage and advertising).

Why Do Health Care Prices Vary Widely?

For the same reason prices in any marketplace vary — business owners all set their own prices. The term in economics is “price dispersion.”

When confronted with evidence of price dispersion, many are quick to point out that even in markets for seemingly homogeneous products, subtle differences among the services offered by competing firms might lead them to charge different prices for the same product.”²⁴

In fact, “empirical studies spanning more than four decades ... reveal **that price dispersion is the rule rather than the exception** in many homogeneous product markets.”²⁵ In other words, price variation for the same product or service is *not unusual or uncommon*.

Information and Internet Transparency Doesn't Eliminate Price Dispersion

Often, it is the *belief* of some that perfect information will prevent price dispersion. However, that has not been true thus far. The investigators in another study concluded “that prices for identical consumer electronics products listed by multiple retailers display considerable and persistent price dispersion. On average, the highest price for a consumer electronics product is 57% above the lowest available price.”²⁶

There are other reasons for variation of price as well. For instance, as a protection against pricing agreements, federal and state antitrust laws are intended to act like guardrails to permit a working free market. By preserving competition, consumers receive a better deal and better products. The laws, therefore, attempt to prevent activities that decrease competition in a marketplace.

In the early and mid 20th century, there was a line of legal thought that learned professions, such as the legal and medical professions, were exempted from the application of antitrust law by the “learned profession” doctrine. The learned profession doctrine essentially provided that the activities of a profession are governed by a code of ethics, thereby rendering the services provided by professionals outside the notion of commerce as understood by antitrust laws. In other words, a profession is motivated to serve the public, in contrast to a trade or business where the motivation is to profit. When the issue finally reached the Supreme Court of the United States for decision in 1975, the Court rejected the learned profession doctrine and held that the nature of a profession does not provide safe harbor from antitrust law enforcement.²⁷

²⁴ “Information, Search, and Price Dispersion.” (draft) *Handbook on Economics and Information Systems*. Elsevier, T. Hendershott, ed. <http://faculty.haas.berkeley.edu/rjmorgan/Information%20Search%20and%20Price%20Dispersion.pdf>.

²⁵ Id.

²⁶ Baye, Michael, et. al. “Persistent Price Dispersion in Online Markets.” www.bus.indiana.edu/riharbau/RePEc/iuk/wpaper/bepp2006-12-baye-morgan-scholten.pdf.

²⁷ Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

For the sake of brevity, this paper will focus on the Sherman Act. The Sherman Act prohibits every contract, combination, or conspiracy in the unreasonable restraint of trade. The Supreme Court ruled that the Sherman Act does not prohibit *every* restraint of trade, only *unreasonable* restraints. What the Supreme Court grants with one hand, it takes away with another. In the plethora of antitrust case law, the federal courts have constructed a catalog of unredeemable commercial activities called “per se violations.”

Per se violations are:

- Price fixing: An agreement among competitors on price or terms that tend to affect price.
- Division of markets: An agreement on market share among competitors.
- Boycotts or concerted refusals to deal: An agreement not to deal with certain parties.
- Tying arrangements: A refusal to provide one service unless another service is also purchased.

A violation of the Sherman Act by an individual is punishable by up to three years imprisonment, a \$1,000,000 fine, or both. Companies can be fined up to \$10 million.

This is not a hypothetical threat, nor is antitrust enforcement limited to large organizations or “big-time” conspiracies. The Federal Trade Commission (FTC) recently has pursued antitrust enforcement against the Music Teachers National Association, Inc. (MTNA), which represents more than 20,000 music teachers nationwide. The FTC has alleged that the association and its members restrained competition in violation of antitrust laws through an ethics provision that restricted members from soliciting clients from rival music teachers.

As you can see, competitors have compelling legal reasons why they can’t collude to eliminate “variation in prices.” Of course, many may remember the Trust Tycoons of the Gilded Age in American industrial history. They sought to eliminate competition and at the same time eliminated variation in prices with the intention of raising prices later.

State Study on Price Dispersion

New Hampshire instructed its Division of Insurance to explain *hospital* price dispersion. The New Hampshire Division arrived at the following conclusions:

A hospital’s cost and case mix are the most consistent predictor of a hospital’s commercial prices for both inpatient and outpatient services. This suggests that hospitals and payers seriously consider patient acuity and service complexity when negotiating payment rates and corresponding payment models.

For inpatient services, the higher a hospital’s occupancy rate, the more likely it is to have higher commercial prices. One reason for this finding may be that hospitals that have higher demand for their beds may command higher prices from insurers....

Finally, the analysis indicated some relationship between a hospital’s public payer mix and its level of commercial prices. If hospitals shift the cost of underpayments from public payers to private payers, we would expect to see higher commercial prices associated with higher public payer mix. However, the results of the analysis were mixed.²⁸

In other words, there was indeed price dispersion, but it was generally explained by cost, case mix, and demand for hospital services.

²⁸ “Analysis of Price Variations in New Hampshire Hospitals.” New Hampshire Insurance Division. www.nh.gov/insurance/lah/documents/umms.pdf.

Everyone Doesn't Pay the Same Cash Amount? Isn't That Price Discrimination?

The sentiments behind this question have an element of “truthiness” but not much else.

Truthiness (noun)

1. “truth that comes from the gut, not books” (Stephen Colbert, Comedy Central’s “The Colbert Report,” October 2005)
2. “the quality of preferring concepts or facts one wishes to be true, rather than concepts or facts known to be true” (American Dialect Society, January 2006)²⁹

Most would not actually agree, in practice, with the general statement that everyone must pay the same amount (the charge is always the same; it is the payment that may change).

Price discrimination happens every day in every type of business. Price discrimination occurs when someone gets a senior discount at the movies or a college student gets a price break on books. People of low-income may receive charity or hardship discounts because they can’t afford the full price of a service. **Typically, it is a free market function left to the business to determine the basis for its discounts.** Sometimes, price discrimination serves as a method for a business to give back to the community through free products/services offered to church fundraisers, our veterans, or police officers. Other times, it may serve as a method of bringing in a preferred target market (such as ladies night at a local drinking establishment) or to encourage the use of services on low-use days (such as Saturday-night stay discounts for airfares). A grocery store coupon is another example of price discrimination.

Consider this explanation of price discrimination:

Price discrimination occurs when two users are shown inconsistent prices for the same product (e.g., Travelocity showing a select user a higher price for a particular hotel). Contrary to popular belief, price discrimination in general is not illegal in the United States ..., as the Robinson-Patman Act of 1936 (a.k.a. the Anti-Price Discrimination Act) is written to control the behavior of product manufacturers and distributors, not consumer-facing enterprises. It is unclear whether price discrimination targeted against protected classes (e.g., race, religion, gender) is legal. Although the term “price discrimination” evokes negative connotations, it is actually a fundamental concept in economic theory, and it is widely practiced (and accepted by consumers) in everyday life.³⁰

Texas already has a law against price discrimination for services paid by insurance (which includes health insurance):

- (a) A person commits an offense if:
 - (1) the person knowingly or intentionally charges two different prices for providing the same product or service; and
 - (2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service.
- (b) An offense under this section is a Class B misdemeanor.³¹

The Texas law makes exceptions for charity discounts, hardship discounts, participation in federal and state programs (which many times pay at below cost), and for those who may be uninsured.

²⁹ Merriam-Webster’s #1 Word of the Year (2006). www.merriam-webster.com/info/06words.htm.

³⁰ See Hannak, Aniko, et al. “Measuring Price Discrimination and Steering on E-commerce Web Sites.” www.ccs.neu.edu/home/cbw/pdf/

³¹ Texas Insurance Code §552.003.

However, readers should be aware that the differing cash payments made under a health insurance contract are *not* forms of price discrimination.

Non-Cash Payment for Medical and Health Care Services

Many who are concerned about price discrimination often overemphasize the cash amount that is exchanged in an insurer-medical provider transaction. Remember the answer to “what is price?” above. The billed charge is the price that is set by the physician or provider and can be collected in-cash and in-kind (non-cash).

The cash payment is only part of the economic exchange that comprises full payment for a service. The value of an insurance contract is more than merely the contract amount — it includes a number of in-kind (non-cash) items as well. Consider the following two figures for a service with a charge of \$1,500. **(Note: The charge/price is always the same.)**

Insurer A: Patient Benefit Design 80/20 Coinsurance

In-Network	\$1000 Deductible Not Met vs. Met	
Physician/Hospital/Provider Charge	\$1500	\$1500
Insurer A Network Participation Value (Patient Steerage, Prompt Pay, Lower Expenses, Predictable Payment, etc.)	(\$500)	(\$500)
Contracted Payment Rate	\$1000	\$1000
80% Insurer Co-Insurance Payment	\$0	\$800 (\$1000 X 80%)
Patient Payment Responsibility	\$1000	\$200 (\$1000-\$800)

Note how **the full billed charge is collected in-cash and in-kind** in all the scenarios above. There is a non-cash exchange taking place between the insurance company and physician or provider — titled in the figures, “Network Participation Value” — which represents the value assigned to the various in-kind non-cash services provided by the insurer. For example, Texas Prompt Pay laws only apply in contracted situations, thus applicability of a timeline and penalties in payment is a valuable component of the relationship provided in exchange for the medical service. It is not an exchange of money, but it is very valuable to a medical practice to know an insurer will make timely payments. The same is true of “steerage.” The number of possible interactions with patients is a valuable non-cash service the insurer provides to physicians and providers through the network structure (differing co-insurance) and is just like a volume discount that occurs in other business transactions.

Insurer B- Patient Benefit Design 80/20 Coinsurance

In-Network	\$1000 Deductible Not Met vs. Met	
Physician/Hospital/Provider Charge	\$1500	\$1500
Insurer B Network Participation Value (Patient Steerage, Prompt Pay, Lower Expenses, Predictable Payment, etc.)	(\$300)	(\$300)
Contracted Payment Rate (Insurer B Contract Rate Different - This Insurer has Fewer Members & More Expense due to Administrative Policies, i.e. Preauthorization, Less Predictable Payment History)	\$1200	\$1200
80% Insurer Co-Insurance Payment	\$160 (((\$1200-\$1000)x 80%)	\$960 (\$1200 x 80%)
Patient Payment Responsibility	\$1040 (\$1000 + (\$200 x 20%))	\$240 (\$1200 x 20%)

You can also see how the business practice of an insurer can harm the value of the in-kind non-cash economic exchange. In the figures above, Insurer B imposes paperwork and hassles in the administration of the health insurance benefit. These obstacles have cost that is accounted for in the agreement and cash/non-cash exchange.

So, the law does not permit price discrimination because an insurer is paying part of the cost, and, typically, physicians and providers receive full payment of the charge through cash and in-kind services, meaning the charge is always paid. Where price discrimination does occur it is, in the medical context, typically to deal with government program schedules, patient charity, and patient financial hardship.

Do I Have Recourse If I Believe I Have Been Overcharged?

Texas does prohibit improper billing. Texas Health and Safety Code §311.0025 (a) states:

(a) A hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payor a bill for a treatment that the hospital, facility, or professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

The Department of State Health Services has jurisdiction to enforce this provision against hospitals and facilities.

The Texas Medical Board (TMB) may also enforce this provision. The Texas Medical Practice Act grants express jurisdiction over this topic:

Sec. 164.053. UNPROFESSIONAL OR DISHONORABLE CONDUCT. (a) For purposes of Section 164.052 (a)(5), unprofessional or dishonorable conduct likely to deceive or defraud the public includes conduct in which a physician: ... (7) violates Section 311.0025, Health and Safety Code;

Complaints to TMB may be filed by calling the Complaint Hotline at (800) 201-9353.

What Can I Do if I Think My Coverage for Medical Services Should Have Addressed My Loss/Liability?

If you are a health insurance customer and unhappy with the amount left for you to pay for an out-of-network service you received, then the Texas Department of Insurance can take your complaint. Call their complaint line at (800) 252-3439, and tell them your insurer has failed to fairly settle the claim. If you think your network doesn't have as many physicians or hospitals as it should, you can file a complaint about that as well. Just tell the agency you think the network is inadequate for what you paid in premium. Also, if you get coverage from your employer, complain to your employer's human resources department.

If you don't want to complain, don't worry, a health insurance customer can still get full credit for every penny you pay. In Texas, our health insurance regulations say that if you provide proof of what you paid for non-network emergency services, your payments will count toward your in-network deductible and out-of-pocket maximum. Call your insurer for information on how to get credit; the number is on the back of the insurance card.

How Can a Physician Have a Contract But Still Be Out of Network?

A network is merely the collection of contracts that exist between insurers and health care providers. The contract contains agreements on material terms such as willingness to take new patients and settlement of claims.

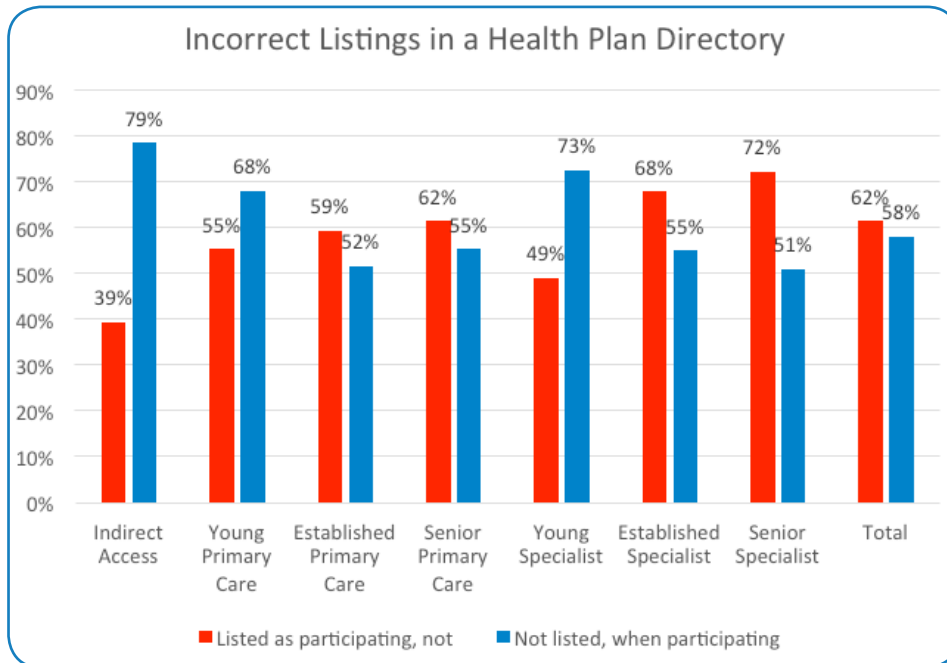
Interestingly, a physician may have a contract with an insurance company, but only be included in *some* of the insurance company plans. For example, United Healthcare recently terminated a large number of physicians from its Medicare Advantage plans, but kept those physicians in-network for some commercial plans.³² With the development of narrow networks, the practice of including contracted physicians and providers in some networks but not others has become much more common.

³² "SeeUnitedHealth Culls Doctors From Medicare Advantage Plans." *WSJ*. <http://online.wsj.com/articles/SB10001424052702303559504579200190614501838>.

This means a physician can be contracted with United Healthcare **but still out of network** for some United Healthcare consumers. According to a Medscape article, “UHC has sent such a letter to thousands of physicians in the US, specifying that the cuts apply only to their Medicare Advantage contract, not to any other UHC plans they may take.”³³

How Do I Determine Who Is In Network and Out of Network?

The insurance company must maintain a directory of contracted physicians who are participating in their plans. However, the format can change from insurer to insurer, and the directories are notoriously inaccurate.



A recent survey of Texas physicians found that a majority of physicians have detected cases where they were listed incorrectly in a health plan's directory.³⁴ Based on TMA's 2012 survey findings, health plan directories frequently misrepresent the plan's actual network. In fact, the survey found that **62 percent of physicians had detected cases in which they were listed as participating when they were not, and 58 percent of physicians had detected cases where they were not listed when they were participating in a plan.** (See chart below.) The inaccuracy of health plan directories acts as a deception

to the insurance consumer when he or she purchases an insurance product with a network benefit and misleads insured persons when they seek to access the benefits they have purchased.

Are There Network Inadequacies in Texas?

TMA has collected network information on network hospitals and the facility-based physicians who practice on those campuses. TMA could not locate this information for certain large insurers, so the information provided here is not likely to offer a complete catalogue of all possible network inadequacies. TMA has posted on its website at www.texmed.org/networkadequacy Excel spreadsheets with all of the network information gathered, as represented by the health plans as of December 2014, in the preparation of this whitepaper.

TMA would bring readers' attention to the following.

Humana Health Plan, according to its own documents published on its website, does not have contracts with emergency department physicians in approximately 54 percent of its in-network hospitals. It does not have network physicians offering radiological services in 31 percent of its network hospitals. Additionally, the company does not contract with anesthesiologists in 36 percent of its network hospitals.

³³ Stiles, Steve. "Unfair Advantage? United Healthcare Boots Thousands of MDs From Its Part C Medicare Plans." www.medscape.com/viewarticle/813318?nlid=37283_1885&src=wnl_edit_dail.

³⁴ See Texas Medical Association Survey of Physicians, 2012. www.texmed.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25268&libID=25269.

United Healthcare, the health insurer of choice of the State of Texas Employee Retirement System, has better numbers, though not much better in regard to emergency physicians in network hospitals. Approximately 40 percent of the hospitals the company contracts with do not have a contracted emergency physician or physician group.

For illustration purposes, you will find below a chart created from the insurer information made available on the Internet to the public as of Dec. 1, 2014. All of the hospitals on the left side of the grid are network facilities for each of the three plans for which the information was available. (TMA staff, after a diligent search, could not locate chart information for any other carriers.) The chart is for network Austin hospital services and the emergency services provided at those network facilities. Hospitals that were not contracted with all three insurers were omitted from the chart.

This chart, for a single city served by the three carriers for which we have information, provides examples of each and every deficiency that plagues network coverage and directories.

(1) Inadequate Networks.

Consumers covered by Humana in Austin have only three network hospitals (of the hospitals in-network with the three carriers) where in-network emergency services are available. Is this the coverage their insured persons expect? No, it is not.

**Austin
Three Carries — Common Network Hospitals**

	Emergency		
	Blue Cross Blue Shield	United Healthcare	Humana
Dell Children’s Medical Center	Emergency Medical	Dell Children’s Med Ctr/Central TX	None In Network
Heart Hospital of Austin	ACS Primary Care Physicians	ACS Primary Care Physicians SW	None In Network
North Austin Medical Center	Capitol Emergency	Capital Emergency Assoc.	Capital Emergency Associates [Sic]
NW Hills Surgical	Emergency Staffing Solutions	None In Network	N/A
Seton Medical Center	Emergency Services Partners - Austin	Capital Emergency Assoc. [NOTE - May be inaccurate]	None In Network
Seton Northwest Hospital	Emergency Service Partners - Austin	Capital Emergency Assoc. [NOTE - May be inaccurate]	None In Network
Seton Southwest Hospital	Emergency Services Partners - Austin	None In Network	None In Network
St. Davids Hospital	Capitol Emergency	Capital Emergency Assoc.	Capital Emergency Associates [Sic]
St. David’s South Austin Medical	Capitol Emergency	Capital Emergency Assoc.	Capital Emergency Associates [Sic]
University Medical Center At Brackenridge	Daughters of Charity Health Services	Capitol Emer Staff PA	None In Network

Of the hospitals that are in-network with all three carriers, two-thirds of Humana’s network hospitals have out-of-network emergency services. Yet Humana is permitted to sell a network product to Texans in Austin.

(2) Directories Are Inaccurate. The information provided by the insurers is inaccurate. Humana has misspelled the name of “Capitol Emergency Associates.” Even worse, United Healthcare, as of December 2014, indicates that Capitol Emergency Associates is the emergency physician group for two hospitals where the group providing the service is actually Emergency Services Partners (as confirmed by accessing the Emergency Services Partners website). So, if a United Healthcare insured person goes to Seton Medical Center or Seton Northwest in Austin believing the emergency services are in network — that insured person will discover the insurer has misdirected them to an out-of-network physician group. The insured person would be misled by the directory entry.

(3) Physicians Are Willing to Contract; Some Insurers Are UNwilling to Contract. Interestingly, Blue Cross and Blue Shield has network agreements with the groups Humana has kept out of network. In other words, physicians are willing to contract in each network hospital. Humana is unwilling to offer a reasonable arrangement similar to arrangements these physicians have agreed to with other insurers. The question in Austin then is, “Why can’t Humana come to an agreement with physicians where Blue Cross and United Healthcare have managed to contract with physicians?” The problems in Austin are created by some of the insurers, but it is certainly not caused by the physicians.



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