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. **Health literacy and education are needed at point of purchase.**

   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.

2. **Insurers need to provide brokers and agents better information about the policies they sell.**

   Insurers should be required to provide brokers and agents 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 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.

3. **A network warning notice should be prominently displayed and provided 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 applicable policies and in all their provider directories. The notice should clearly state:

WARNING: Limited benefits will be paid when out-of-network physician or health care providers are used. Please be aware that when you receive services from an out-of-network physician or health care provider for a covered nonemergency or emergency service, <u>our out-of-network payments are not based upon the physician or health care provider's billed charges</u>. 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 for those services. Out-of-network 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.

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4. Insurers should be responsible for telling their customer about the network status of physicians and others providing care for any prior authorized procedure.

For elective services prior-authorized by the insurer at an in-network or out-of-network facility, insurers should be required 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 their out-of-pocket responsibility for any out-of-network services related to providing the prior-authorized service and the balance bill(s) they may receive.

5. Expand the applicability of the current mediation process to ALL out-of-network physicians and providers at a facility.

- In addition to facility-based physicians, mediation should be expanded to apply to all out-of-network physicians, health care professionals, and vendors providing services at a facility, 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. The current mediation threshold of a $500 balance after copayments, deductibles, and coinsurance should be maintained.
- Texas patients must continue to be the initiators of Texas' mediation process for the surprise/balance billings they receive that meet the $500 out-of-network threshold. The patient should remain the nexus for any discussion that takes place about what the insurer did or did not pay for the out-of-network services that resulted in the patient receiving a "surprise/balance bill."

6. Use a standard disclosure form to remind patients about whom they need to contact.

Physicians and providers performing planned procedures, surgeries, or deliveries at a facility should be required to provide to patients a standard disclosure form that identifies the name and phone number of other physicians or nonphysician 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 nonphysician practitioners for further 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 nonphysician practitioners 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.

7. Increased network adequacy oversight by the Texas Department of Insurance is needed.

There must be mandatory, increased state agency oversight of the adequacy of all of an insurer's 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.

Physicians Caring for Texans

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