

TDI Response to the House Select Committee on  
Statewide Health Care Costs  
Request for Information of August 13, 2020

October 1, 2020

CHARGE 1: Examine the primary drivers of increased health care costs in Texas. This examination should include a review of:

- 1. Current health care financing strategies;**
2. fragmentation of the care delivery administrative burden;
3. population, health, and social factors that contribute to rising rates of chronic disease and poor health;
- 4. insurance coverage and benefit design;**
- 5. lack of transparency in the cost of health care services;**
6. regional variations in the cost of care;
7. consolidation and lack of competition in the provider and insurance markets;
8. health care workforce capacity distribution; and
- 9. fraud, abuse, and wasteful spending.**

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### **Health insurance**

Most Texans with private health insurance have federally regulated self-funded plans—meaning employers take on the risk and responsibility of paying covered claims.

The Texas Department of Insurance (TDI) solely regulates private fully-insured health plans that accept the risk and responsibility of paying covered claims. Around 15% of Texans are covered by health plans that TDI regulates. TDI does not regulate government health programs such as [Medicare](#) and [Medicaid](#), but does regulate plans purchased under the Affordable Care Act through Healthcare.gov.

A resident has such a fully insured health plan if TDI or “DOI” (for department of insurance) is printed on their insurance card. For such plans, TDI oversees solvency, network adequacy, and claims processing and payment requirements including prompt pay and out-of-network payment standards. TDI does not regulate contracts between insurers and health care providers, including payment terms and coverage disputes.

### **Health insurance costs and plan types**

Insurance costs vary. All health plans require the holder to pay premiums plus a share of subsequent health care costs. Plan participants also usually pay an annual deductible as well as copayments and coinsurance:

- A premium is what a plan member pays monthly for their insurance. For a large employer plan (sold to a company with more than 50 employees), premium amounts are based on the employer group's claims experience. For an individual or small group plan, the Affordable Care Act requires premiums to be based on claims experience across the entire individual or small group market. Federal rules also establish a standard age curve that dictates how much premiums increase with age. Health plans also may charge a person a surcharge for tobacco use. Premiums, set for a year at a time, usually increase when the plan member renews enrollment.
- A deductible is the amount a member must pay each year before their health plan starts picking up costs. For example, if the deductible is \$1,000, the plan won't pay anything until the plan holder has paid \$1,000. Some plans have more than one deductible. An individual might have one deductible for in-network care and another for out-of-network care. Most family health insurance policies have individual deductibles and family deductibles. Amounts credited towards an individual deductible are also credited toward the family deductible.

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- Copayments are fees paid each time a beneficiary gets a covered health service. For example, a person might have to pay \$25 to visit their doctor and \$15 to fill a prescription.
- Coinsurance is an amount paid for a covered service after a plan member has met their deductible—usually a percentage of the cost of the service. For example, a plan might pay 80% of the cost of a surgery or hospital stay. The plan holder pays 20%. The percentage paid in coinsurance varies by plan.

Federal law caps out-of-pocket payments by a plan member in a year. In 2020, the limits were \$8,150 for a person, up from \$7,900 in 2019, and \$16,300 for a family, up from \$15,800 in 2019. After reaching the limit, a plan member does not have to pay copayments or coinsurance for the rest of the plan year.

### **CHARGE 1.4: Insurance coverage and benefit design**

#### **Types of network plans**

TDI regulates major medical plans, which with minor exceptions must satisfy [state](#) and [federal](#) coverage mandates. The four types are:

- Health Maintenance Organizations (HMOs);
- HMO point-of-service plans;
- Preferred Provider (PPO) plans; and
- Exclusive Provider (EPO) plans.

All these plans contract with doctors and other health care providers to treat members at discounted rates. Chosen providers make up each plan's network. The plans limit a member's choice of doctors or encourage the use of doctors in the plan's network. In return, consumers pay less out of pocket. Plans differ over the extent to which individuals may visit doctors outside the network and whether a person must have an in-network physician overseeing their care.

#### **HMOs**

An HMO usually pays for a member's care if they visit doctors and hospitals in the plan's network. There are exceptions for medical emergencies and for medically necessary services not available in the network. HMOs are required to make sure their providers give quality care; they are subject to greater TDI oversight than other kinds of plans.

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HMO plans may require a member to choose a primary care physician to help manage care. They also usually require a patient to get a referral from their primary care physician before visiting a specialist.

### **HMO point-of-service plans**

Point-of-service plans, offered as accompaniments to HMO plans, let a beneficiary visit any doctor. But out-of-pocket costs will be lower for going to doctors in the plan's network. A plan member usually must have a primary care physician and get referrals to specialists other than OB/GYN.

### **PPOs**

A PPO plan gives the member the option of using out-of-network doctors and hospitals and does not require them to choose a primary care physician or get referrals before visiting a specialist. Out-of-pocket expenses likely increase, though, for using out-of-network services.

### **EPOs**

EPOs are a relatively new network plan blending features of PPO and HMO plans. Like an HMO, an EPO usually does not cover the costs of visiting providers outside the plan's network. But members are not required to choose a primary care physician and may visit in-network doctors and hospitals, including specialists, without getting a referral.

### **Alternate choices**

Alternative health plans might not be regulated by the state. They also do not have to comply with the Affordable Care Act including its mandate that plans cover preexisting conditions.

Alternative plans include:

- Short-term plans
- Limited benefit plans
- Subscription plans
- Discount plans
- Health care sharing ministries
- Association plans

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### **Short-term plans**

Short-term health plans last 12 months or less, but can sometimes be renewed for up to three years. These plans usually offer fewer benefits and less coverage than major medical plans, and are not guaranteed to be issued or renewed.

### **Limited benefit plans**

There are several kinds of limited benefit plans, each of them paying some costs:

- **Accident plans** pay part of a member's bills for some injuries.
- **Disease plans** pay part of a person's bills for a designated illness, such as cancer.
- **Fixed-indemnity plans** pay a set amount for specified benefits (such as \$100 per day that a member is hospitalized).

### **Subscription plans (not insurance)**

Subscription plans, also known as direct care or concierge care plans, typically require members to pay a monthly or annual fee to use a doctor or service. Other fees may be charged for each visit, laboratory work, or other services. If a participant needs care that the subscription plan does not cover, they might have to pay the full cost.

### **Discount plans (not insurance)**

Members of discount health plans pay monthly fees in return for reduced rates on specific health care services. Common discount plans cover vision, hearing, or pharmacy services. While they may use the term "PPO" to describe their provider network, the plans are not traditional health plans.

### **Health care sharing ministries (not insurance)**

Health care sharing ministries are nonprofits that limit membership to people of a similar faith. Members make monthly payments to pay the medical expenses of other members. Health care sharing ministries that meet the statutory standards for exemption are not regulated by the state, and there is no guarantee they will pay claims. They also might not cover preexisting conditions or provide as many benefits as major medical plans.

### **Association health plans**

There are many types of associations that offer various types of benefits, including health plans and other insurance products. Some are set up by member-based associations, others by employers. Association plans are generally subject to state and federal laws, but do not have to comply with the Affordable Care Act and might not cover as many services as major medical plans.

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### TDI draft rule for employer associations

In September, TDI [proposed](#) amending definitions in 28 TAC Chapter 26, Subchapter C, because of a clarification of federal law. The proposal would align Texas requirements with federal law to allow employer groups or associations to fulfill the federal definition of bona fide employer associations.

### Network adequacy requirements

Health plans employ networks of providers to contain costs. In a network, each provider contracts with the plan to care for its members for an agreed payment. If a doctor or facility has no contract with a plan, they are considered out-of-network and may charge full price.

[By law](#), a network must have a sufficient number of geographically dispersed licensed providers to meet members' medical and health care needs.

**Geographic distribution:** For each physician and provider type, an in-network option must be available within a certain number of miles:

Categories of care	HMO	PPO/EPO
Primary care and general hospital care	30	30 (nonrural); 60 (rural)
Specialty care (including pharmacies) and specialty hospitals	75	75

**Availability and accessibility of covered care:** The following types of care must be available to HMO, PPO, and EPO plan members within specified times:

Categories of care	Timeframe
Emergency care and urgent care	At all times
Routine medical conditions	Within 3 weeks
Routine behavioral health conditions	Within 2 weeks
Preventive services for children	Within 2 months
Preventive services for adults	Within 3 months

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**Physician and provider types:** TDI network adequacy reviews apply to provider types including: acute care hospitals; ambulatory surgical/outpatient facilities; physical, occupational, and speech therapy facilities; skilled nursing facilities; durable medical equipment providers; home health providers; pharmacies and pharmacists; and dialysis facilities. Physicians subject to adequacy reviews include cardiologists; emergency room physicians; anesthesiologists; surgeons; otolaryngologists (ENT); primary care physicians; radiologists; pulmonologists; dermatologists; pediatricians; orthopedists; and OB/GYNs.

### **Assessment of network adequacy compliance**

To determine if a network fulfills the state's geographic distribution standard, TDI requires insurers to submit in-network provider listings and plotted service area maps for each physician and provider type. Using Geo-Access or similar mapping technology, TDI staff determine if the standard is met.

To determine if a network complies with the state's availability and accessibility of covered care standard, TDI uses each listing of in-network providers to verify that:

- Contracted physicians have admitting privileges at in-network acute care hospitals.
- Insured individuals have access to in-network providers within required timeframes.

TDI assesses network adequacy compliance when:

- Any managed care plan files its network adequacy report.
- An HMO submits a license application or a request to expand into more counties.
- A triennial quality of care examination is conducted.
- New PPO and EPO products are filed for TDI review.
- An insurer notifies TDI of a significant change in its network configuration.
- TDI receives complaints suggesting weakness in a network's adequacy.

### **Network adequacy compliance options**

When a plan does not meet state standards, the insurer must take one or more actions:

- File an access plan explaining how network gaps will be covered and members have access to care, and that out-of-network providers get fair compensation.
- Reduce its service area to meet the standards.
- Stop marketing in parts of the state.
- Stop marketing entirely and withdraw from the market.

If the insurer does not take corrective action, TDI may issue a sanction or penalty.

An access plan filing must specify where standards are not met. The plan also documents how an insurer will make available necessary health care not available to members through

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in-network providers. An access plan also specifies steps the insurer will take to increase its contracted providers and improve network adequacy.

### Access plans, rural and urban distinctions

Many rural counties have few or no available specialists, so providers send patients to urban areas for specialized care. Due to the vast rural demographics of Texas, access plans relating to shortage of particular provider types are common.

Access plans based on inability to negotiate provider contracts are more common in urban areas.

The table below illustrates the number of networks for commercial health plans filed with TDI in 2020.

Type of plan*	HMO	PPO	EPO
Total number of networks	60	94	19
Number of networks with access plans	57	91	19

\* Table updated 9/17/2020.

### Enforcement of network adequacy compliance

After TDI staff inform an insurance company of potential compliance issues, the company has a chance to submit information showing the insurer is in compliance or submit filings intended to achieve compliance. This process resolves most concerns about network adequacy. However, when a company does not become compliant in a timely fashion, staff refer it to enforcement for possible disciplinary action.

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Plans must submit annual network adequacy reports to TDI. The following chart shows the number of annual reports received and the number of disciplinary referrals associated with late or non-filers per calendar year:

<b>CY</b>	<b>Reports received</b>	<b>Disciplinary referrals</b>	<b>Penalties</b>
2017	253	10	\$274,000
2018	204	3	\$700,000
2019	237	1	\$115,000

\* Table updated 9/30/2020.

### **CHARGE 1.5: Lack of transparency in the cost of health care services**

Costs of health care services and payments vary by location and contract terms. These variances plus differences in cost transparency can confuse stakeholders including consumers, regulators, and policy makers.

Over recent years, efforts have been made to enhance transparency. In 2007, for example, lawmakers passed into law Senate Bill 1731, resulting in TDI creating the online [Texas Healthcare Costs](#) to help consumers avoid unexpected health care bills.

Texas law also allows consumers to request a cost estimate from a health care facility, provider, physician, or their health plan before receiving care. Insurers and health care providers must provide requested estimates within 10 business days. State law also requires insurance companies to post online information on the estimated financial responsibility for the health care provided to an enrolled member. Many insurers offer shopping tools enabling consumers to obtain estimates for the cost of certain services from in-network providers.

### **White House executive order**

In June 2019, President Trump issued an [executive order](#) "to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients' decision-making and allow patients to compare prices across hospitals."

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In November 2019, the U.S. Department of Health and Human Services issued [proposed rules](#). The rules have been [challenged](#) in court by the American Hospital Association and others who say the changes would result in anti-competitive behavior in the health market.

### **Balance billing**

Balance billing, sometimes called “surprise billing,” is one indicator of a lack of transparency and knowledge about the cost of healthcare. Balance billing occurs when a consumer receives a bill above their plan’s cost-sharing requirements for services rendered by an out-of-network provider in an emergency setting. Balance billing also occurs when a person gets treated at an in-network facility by an out-of-network provider.

SB 1264, passed into law in 2019, bans providers from sending balance bills to patients in those cases. Under the law, providers and facilities can apply for arbitration or mediation, respectively, to resolve payment disputes with insurers. The law keeps consumers out of the dispute process. In July 2020, TDI posted a [preliminary report](#) on implementation of SB 1264.

Consumers still may seek mediation for balance billing connected to procedures performed before January 2020. Records show that mediation requests surged years after the consumer mediation program’s inception in 2009. Requests to TDI for mediation totaled less than 20 in fiscal 2010, 2011 and 2012, respectively. There were subsequently over 4,600 requests in fiscal 2018 and over 8,300 requests in fiscal 2019. Over the years, consumer savings due to mediation of surprise bills has exceeded \$67 million, TDI estimates.

### **CHARGE 1.9: Fraud, abuse, and wasteful spending**

People commit insurance fraud when they lie or misrepresent facts for financial gain. Since companies spread the costs of claims among policyholders, fraudulent insurance claims drive up premiums. Health care fraud may include unauthorized or phony insurance companies, providers billing for services not rendered or for unneeded tests and procedures, identity theft to secure health benefits, false disability claims, and more.

In the three fiscal years running through August 2020, TDI’s Fraud Unit received more than 42,000 reports of suspected insurance fraud. More than 4,700 reports, nearly 9%, related to health care with the most common reported health care scheme involving provider billing fraud. In FY2020, the Fraud Unit referred 19 health care fraud related investigations for prosecution. As of September 2020, the Fraud Unit was pursuing 61 investigations involving allegations of health care fraud.

Questions? Contact [GovernmentRelations@tdi.texas.gov](mailto:GovernmentRelations@tdi.texas.gov).