January 12, 2015

Mr. J.P. Wieske
Chair, Network Adequacy Model Review (B) Subgroup
c/o National Association of Insurance Commissioners
444 North Capitol Street, N.W., Suite 701
Washington, D.C. 20002
Attention: Jolie H. Matthews, Esq.

Dear Mr. Wieske,

The Texas Medical Association (“TMA”) is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: “Physicians Caring for Texans.” TMA’s diverse physician members practice in all fields of medical specialization.

TMA appreciates this opportunity to comment on the Exposure Draft of the National Association of Insurance Commissioners Health Benefit Plan Network Access and Adequacy Model Act. Consistent with its mission, TMA has a keen interest in advocating for laws and regulations promoting patient well-being and access to medical care, efficiency in the delivery of healthcare and economic viability of physician practices. TMA offers the following specific comments.

I. **Subgroup Request for Discussion Regarding Patient Billing by Physicians and Other Providers. Workgroup Should Not Prohibit Physician Billing.**

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. The health insurance many consumers purchase are managed care products. Preferred Provider Organizations (PPOs), which are known as Preferred Provider Benefit Plans (PPBP) in Texas, 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 a belief that they will receive the highest level of benefit for all services at an in-network hospital. However, the PPO benefit they have purchased is actually 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. It is this unfair and unjust nature of the coverage (as those terms are used in insurance regulation) from which the consumer representatives request relief. It is the limited coverage, not the physician bill, which is the cause of the unfairness.

For the specific reasons set forth in this Section (Section I), TMA respectfully opposes any attempt to regulate health care billing in a Model Act regulating insurance policies.
A. **Unfair Discrimination, Unjust Policies and Network Health Benefit Plans**

In Texas, prior to 1986, Preferred Provider Benefit Plans, commonly known as PPOs or PPBPs, were prohibited as they ran afoul of the statutory restrictions 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. A policy that imposes such outcomes unfairly discriminates in the coverage provided to consumers. 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 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:

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.\(^1\)

However, a network benefit continually imposes different levels of coverage on insured consumers who pay the same premiums for the same risk of loss; a circumstance it is not always within a consumer’s ability to avoid. That is the very nature of the product. 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. In other words insured persons are surprised their insurers have a lower financial obligation and that their policies impose increased financial exposure upon them (the consumer) for care received within that in-network hospital.

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 the individual professional 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 which has gone unpaid by the insurer. The bill surprises consumers as they expected complete coverage and settlement by the insurer. Unfortunately consumers, when they most need coverage, especially in emergencies, are now discovering the limitation of the coverage they have purchased. Simply, in emergency circumstances or where they

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\(^1\) 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.
receive a service from a non-network provider at a network facility, the consumer is no longer satisfied with the premium savings network insurance products offer when that means greater financial burden. This outcome is solely the result of benefit design.

With the introduction of narrow networks and ultra-narrow networks, as discussed on the NAIC workgroup conference calls, it is likely more consumers will face greater personal financial exposure.

The Texas Insurance Code provisions regarding unjust policies are found within Chapter 1701. The relevant code provisions are as follows:

Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF APPROVAL OR EXEMPTION. (a) Except as provided by Subsection (d), the commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(b) A form filed under this chapter that contains a coordination of benefits provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. An order of benefits determination provision may not be approved if the provision:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. […]

Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICY FORM APPROVAL. (a) Except as provided by Subsection (b), the commissioner may, after notice and hearing, withdraw approval of an individual accident and health insurance policy form if, after consideration of all relevant facts, the commissioner determines that:

(1) the benefits provided under the form are unreasonable in relation to the premium charged; or

(2) the reserve required by Section 862.102 is not maintained by the insurer on the policies issued on the form.

(b) If an individual accident and health insurance policy form has been on file with the department for at least 360 days and has been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements of this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or
(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder. [...] 

A PPO network insurance product, without meeting an exemption, can run afoul of this general prohibition in two ways. First, the non-network and network benefits provided under the form are unreasonable in relation to the premium charged. If the network is constructed in a manner that is so narrow that benefits are not actually accessible, then the premium collected for that benefit may be unreasonable. An example could be a limitation on the number of infectious disease specialists available in the health carrier network. Infectious disease specialists typically care for patients suffering from HIV/AIDS and without a sufficient number of such specialists an important benefit is withheld by the insurer. The more narrow or incomplete the network, the less valuable is the network benefit. Thus, the premium must correspondingly be lower. Second, a network product can be unjust, encourage misrepresentation, or be deceptive by the fact that network benefits are not available at the preferred level at network facilities for all services. This is one of the complaints put forward by Consumer representatives, consumers are led to believe that all services at a network hospital are covered at the preferred level, but they are, in fact, not all covered at the preferred level.

There may have been several attempts to inform consumers about the limitations of the coverage, but it is possible that marketing messages that a person “is covered” when buying insurance overwhelms specific disclosures about the limited nature of insurance financing.

When a consumer shops for insurance, that person is provided a “Summary of Benefits and Coverage” (SBC). A 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. The SBC is not the only notice a consumer 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 payors as the facility.

In addition to the SBC (required by federal law) above, health insurers have additional 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 consumer is informed in many materials sent to the consumer in conjunction with issuance or renewal of the policy or evidence of coverage, in explanation of payment summaries and the information must be conspicuously displayed on any health benefit plan website that a consumer is reasonably expected to access.
Nevertheless, a PPO plan in Texas has an exemption from the prohibitions on unfair discrimination and offering an unjust policy so long as the insurer meets the obligations under the PPO chapter of the Insurance Code. TMA, based on information and belief, asserts that many states have similar exemptions which permit sale of insurance products that have unfair and unjust elements within their terms. In that light, strict regulation of **network benefits** is crucial to protect consumers.

**Consumer representatives are giving voice to marketplace dissatisfaction with the financing offered by PPO and HMO networks.** The increased financial exposure consumers face is a direct result of the insurer’s benefit design which contains elements that impose unfair discrimination and unjust policy terms.

**B. Network Participation is Not Completely Within Physician Control**

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. With the development of narrow networks the practice of including contracted physicians and providers in some networks but not others have become much more common.

This means a physician can be contracted with United Healthcare but will still be 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.”

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 or health plan sponsor’s option. This is certain to be the case with ultra-narrow networks. In fact, Peter Lee, executive director for Covered California (the insurance exchange/marketplace for that state) has stated “More isn’t always better. The days of every doctor in every network are over.” The idea that an insurer (or an insurance exchange) can limit the network and then exclaim the limited coverage is solely a result of physician contracting behavior is not tenable.

As insurance carriers can restrict or prevent physicians from participating with a particular plan offered by the carriers, imposition on physicians’ ability to bill for services is inappropriate.

1. **Insurance Carrier Unwillingness to Contract**

TMA has collected network information upon 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 does not offer a complete catalogue of all possible network inadequacies.

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TMA would bring readers’ attention to the following in regard to the Texas health insurance market:

Humana Health Plan, according to their own documents published on their website, does not have contracts with emergency room physicians in approximately fifty-four percent (54%) of their in-network hospitals. They do not have network physicians offering radiological services in 31% of their network hospitals. Additionally, the company does not contract with anesthesiologists in 36% of their network hospitals.

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

For illustration purposes you will find below a chart/grid created from the insurer information that is made available on the internet to the public as of December 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/grid information for any other carriers). The chart is for network Austin hospital services and the emergency services provided at those network facilities. With the exception of NW Hills Surgical Hospital (which is not contracted with Humana) hospitals that were not contracted with all three insurers were omitted from the chart to permit easy comparison.
This chart for emergency services, 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. 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/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 is then “**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.

TMA argues the issue with network coverage at network facilities is an inherent problem of the benefit design exacerbated by an insurance carrier un-willingness to contract, to monitor its own network adequacy, or both. Physician billing need not be regulated, rather insurer marketplace activity must be scrutinized.

**C. A Prohibition on Physician Billing is a Governmental Rate Setting**

A prohibition on physician billing patients (through the imposition of a statutory ban) would permit health carriers to evade their obligation to build an adequate physician and provider network. Instead, by prohibiting billing, a state would be granting insurers permission to build their networks, in part, by conscripting non-contracted physicians. That is accomplished by allowing insurers to unilaterally establish the payment rates for all out-of-network physicians. In other words, by prohibiting the billing of a consumer, the Model Act would in essence be charging health carriers with the unilateral authority to set the final payment for physician and provider services at network hospitals. This is a delegated governmental rate setting of health care charges. It is generally improper to confer this authority to a private entity and such delegation is disfavored in Texas case law. TMA suspects other states may have similar case law. As discussed by the Texas Supreme Court “…private delegations clearly raise even more troubling constitutional issues than their public counterparts. On a practical basis, the private delegate may have a personal or pecuniary interest which is inconsistent with or repugnant to the public interest to be
served.” Indeed, that is exactly what we are faced with here - a delegation of rate-setting authority to the party charged with the duty to pay the fee.

The Texas Supreme Court has laid out eight factors to determine the permissibility of a delegation by the Legislature to a private party. Those factors are:

1. Are the private delegate’s actions subject to meaningful review by a state agency or other branch of state government?

2. Are the persons affected by the private delegate's actions adequately represented in the decision-making process?

3. Is the private delegate's power limited to making rules, or does the delegate also apply the law to particular individuals?

4. Does the private delegate have a pecuniary or other personal interest that may conflict with his or her public function?

5. Is the private delegate empowered to define criminal acts or impose criminal sanctions?

6. Is the delegation narrow in duration, extent, and subject matter?

7. Does the private delegate possess special qualifications or training for the task delegated to it?

8. Has the Legislature provided sufficient standards to guide the private delegate in its work?

Even a facial review of the standards above demonstrates that the delegation of rate setting to health plans will fail. In light of the Texas Supreme Court’s factors, all of the following facts disfavor delegation in this case:

- The health plan’s claim settlement activities will not be reviewed by the Insurance Department;
- Physicians have no say in the health plan’s decision on payment;
- The health plan will apply its claim settlement on an individual basis claim-by-claim;
- The health plan has a financial interest in the rates it sets in that lower payments equate to improved health plan revenue;
- The delegation to the health plan is unfettered discretion in settling claims; and
- The health plan does not have special qualifications on this issue as demonstrated by the fact UnitedHealthGroup’s Ingenix subsidiary was accused of a “huge scam that affected hundreds of millions of Americans (who were) ripped off by their health insurance companies.”

Further, as the health plan settles each out-of-network payment on a case-by-case basis, the requirements of the Texas Administrative Procedure Act (or any state APA) will be left unsatisfied.

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3 Texas Boll Weevil Eradication Foundation, Inc. v. Lewellen, 952 S.W.2d 454. (emphasis added).
4 Comments of then NY Attorney General Andrew Cuomo on the initiation of an investigation of Ingenix. See http://www.nbcnews.com/id/28628880/ns/health-health_care/t/health-insurer-accused-overcharging-millions/#.VKxp-8nzOW0
There will be no publication in the Texas Register for notice or an opportunity to comment upon said rates. That would also be the case should an “independent” private authority be granted with such authority. Simply, the methods used to set the rates will not be enforceable under the APA.

A proposed prohibition on physician billing would be an indirect governmental intervention in the health care market place and would permit a health carrier to exercise the broad authority in a circumstance where it failed to either make the effort to contract with the physician or has neglected to make a reasonable contract offer to provide the services in-network. There is no real incentive for the plan to develop its network as it could simply rely upon its determination of payment and the de-facto network established by a prohibition on physician billing.

Regardless of the setting or specialty, if enacted, the effect of a statutory prohibition on physician billing would be an unconstitutional taking of out-of-network physicians’ services. As health plans carriers (acting as the government’s delegate) would be permitted to unilaterally set rates out-of-network without a meeting of the minds there is no assurance that the physician’s fee would be paid as submitted on the claim. Under the United States Constitution, a government-set rate must allow a regulated entity to not only recover its operating expenses, but also to realize returns on its investments sufficient to assure confidence in the continued financial integrity of the enterprise. A prohibition of the type that may be considered shifts insurance risk for out-of-network care from health plans to physicians and other providers. To prohibit physician billing where there is no contract between the health carrier and physicians is to invite a confiscatory rate and an unconstitutional statute.

D. Introducing the Regulation of Medicine into a Model Act for Insurance will Upset Longstanding State Statutory and Regulatory Frameworks

1. Statutory Definition of Practicing Medicine

The statutory definition of practicing medicine in Texas is as follows:

(13) "Practicing medicine" means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who:
(A) publicly professes to be a physician or surgeon; or
(B) directly or indirectly charges money or other compensation for those services.

The workgroup members should note that, although the definition of practicing medicine is drafted in two paragraphs, it actually encompasses at least eight activities. The most relevant element for the purpose of this discussion and the Model Act before you is captured in paragraph (B). When broken down into its components paragraph (B), in summary, provides that all of the following activities are "practicing medicine:"

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6 A license issued by the Texas Medical Board conveys the authority to practice medicine. See Subchapter A, Chapter 155, Tex. Occ. Code and Texas Constitution Article 16, Section 31.
1. Diagnosis of diseases, disorders, physical deformities, or injuries by a person who charges for those services.
2. Treatment of diseases, disorders, physical deformities, or injuries by a person who charges for those services.
3. Offer to treat diseases, disorders, physical deformities, or injuries by a person who charges for those services.
4. The attempt to effect cures of diseases, disorders, physical deformities, or injuries by a person who charges for those services.

As demonstrated above, to charge for a medical service is part of "practicing medicine." Furthermore, the term "charges" as used in the definition is unlimited as to how the charge for services is made by the person. In other words, "charge" can include a specific fee for a particular medical service, a bundled fee for medical services, a membership or concierge fee, capitation, or any other method of obtaining a fee for offering or providing medical services (including on credit).

A license to practice medicine in Texas, therefore, **expressly includes authority to charge money or other compensation** for offering to treat or diagnosing diseases and disorders. The term "charge" in the definition of practicing medicine is not confined to any particular method of payment or any particular type of fee. TMA urges the workgroup to refrain from offering statutory language that modifies the very fundamental definition of “practicing medicine.” To do so would be a radical departure from the traditional regulation of the practice of medicine.

Indeed, to introduce a prohibition upon physician billing into the insurance code would also alter the statutory framework regarding agency responsibility for the practice of medicine. The Texas Occupations Code contains a short, but pertinent, statement regarding the Texas Legislature’s intent regarding the regulation of medicine:

Sec. 151.003. LEGISLATIVE FINDINGS. The legislature finds that:

(1) the practice of medicine is a privilege and not a natural right of individuals and as a matter of public policy it is necessary to protect the public interest through enactment of this subtitle to regulate the granting of that privilege and its subsequent use and control; and

(2) the [Texas Medical] board should remain the primary means of licensing, regulating, and disciplining physicians.\(^8\)

Again, a Model Act that purports to prevent the charging and billing for services, placing said enforcement within an Insurance Code provision, would fundamentally modify the statutory framework for the regulation of medicine. TMA strongly urges against the workgroup undertaking any position on physician billing.

TMA believes its position on this issue is in accord with previous workgroup decisions. Previously, the fact that several states have differing methods of regulating health carriers was cited as a rationale for not adopting a particular Model Act provision. TMA argues this, again, is one of those circumstances where states will have differing methods of regulating medicine and therefore the workgroup should not adopt a prohibition on billing.

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\(^8\) Texas Occ. Code §151.003.
2. **State Laws on Freedom of Choice in Health Care**

TMA would also point out that placing a provision in the Model Act prohibiting physician billing may also run counter to several recent state Constitutional enactments and statutory protections intended to permit direct payment of medical services and patient choice.

For instance, Arizona enacted the following provision and placed it into its state Constitution, in pertinent part:

**SECTION 2. A. TO PRESERVE THE FREEDOM OF ARIZONANS TO PROVIDE FOR THEIR HEALTH CARE:**

1. A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system.

2. A person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.\(^9\)

Ohio and Oklahoma have adopted Freedom of Choice provisions into their state Constitutions. Several other states have placed similar provisions into statute. Specifically, Georgia, Idaho, Indiana, Kansas, Louisiana, Missouri, New Hampshire, North Dakota, Tennessee, Utah, and Virginia have adopted freedom of choice laws. Missouri’s law is especially notable because it is a legislatively-referred state statute, meaning the electorate of the state was able to vote upon and pass the measure. The Missouri Healthcare Freedom law, also known as Proposition C, states in pertinent part (emphasis added):

Section A. Section 375.1175, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 1.330 and 375.1175, to read as follows (emphasis added):

1.330. 1. No law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system.

2. **A person** or employer **may pay directly** for lawful health care services and shall not be required by law or rule to pay penalties or fines for paying directly for lawful health care services. **A health care provider may accept direct payment for lawful health care services and shall not be required by law or rule to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.**

A Model Act provision that prohibits charging or receiving payment directly from a consumer for health care services may find it violates one or all of these state Health Care Freedom Acts. TMA strongly urges the workgroup refrain from a regulation that prohibits physician billing.

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\(^9\) Article XXVII, Section 2, Constitution of Arizona.
II. **Directories**

As members of the workgroup no doubt know, the California Department of Managed Health Care issued a report that found more than 25% of the providers listed in provider directories offered by Anthem and Blue Shield were not accepting patients with Covered California plans or were no longer at the location listed in the directory.

Specifically, among physicians listed as in-network providers for Anthem, the report found that:

- 12.8% did not accept patients with Covered California plans; and
- 12.5% had changed locations.

Among Blue Shield of California providers:

- 8.8% did not accept patients with exchange plans; and
- 18.2% had changed locations.

The DMHC findings in California are very similar to results from TMA’s 2012 physician survey findings that demonstrate 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. 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.

TMA believes the workgroup may receive suggestions from the California Medical Association and Physician Advocacy Institute for the regulation of networks and the directories that communicate the composition of those networks. TMA supports the recommendations those associations may make.

Although TMA welcomes the directory requirements contained in Section 8 of the Exposure Draft Model Act, there is still concern that there is no provision for consumer protection where a network directory misleads a consumer. Earlier in this document, TMA provided an example of how an inaccurate directory would mislead a United Healthcare enrollee/insured to believe emergency services were in network when they are not in network. Such a misrepresentation must not go without some consumer remedy. TMA would specifically offer the following additional language:

If a covered person obtains health care services from a non-participating provider due to an inaccuracy in the provider directory the health carrier shall fully pay the health care provider and ensure that the covered person’s total financial responsibility is no greater than had those services been obtained from a participating provider.

AHIP representatives have made representations in the press that directory accuracy is a “shared responsibility.” TMA would like to dispel that notion. The responsibility to maintain the accuracy of the network directory is solely upon the health carriers. Health carriers voluntarily seek the authority to sell insurance products in the state and they do so with the knowledge of the statutory requirements with which they must meet. When selling a product, the health carriers use the directories to entice new members to purchase insurer network products. The plans then direct their
members to use the directories in making decisions about which health care provider to visit for any particular malady. In essence, a directory is a representation of the plan’s benefits and as such accountability for those representations remain with the seller of the benefits – the insurance carrier.

Furthermore, some insurers place provisions in their provider contracts expressly stating there is no third party beneficiary to the contractual requirements, which may or may not include providing the insurer with credentialing or network status information. An example provision reads:

No Third Party Beneficiary. This Agreement is entered into by and between Physician and [Carrier] solely for their benefit. Except for [Compensation and Member Nonliability and Hold Harmless] there is no intent by either party to (a) create or establish any third party beneficiary status or (b) increase the rights of any Member or any other person, firm, or other entity not party to this Agreement with respect to the duties of either party to any person or create any rights on behalf of any person with respect to either party.

This means any physician contractual promise to inform health carriers about participation and practice location are, by express contract term, owed only to the health carrier. Thus, the carrier alone is accountable for the representations made to the insured person. To attempt to disclaim accountability for the representations insurers make in directories to consumers is inappropriate and should be met by workgroup members with skepticism.

TMA would also remind the members of the workgroup that California has also experienced a number of lawsuits all stemming from inaccurate directories. Those lawsuits are:

1. Felser v. Blue Cross of California, case no. BC550739
2. Cowart v. Blue Cross of California, case no. BC549438
4. Harrington v. Blue Shield of California, SF Superior Ct. case no. 14-539283

Each of those lawsuits allege carrier misrepresentations in directories have led to consumer harm.

III. **Certification as a Substitute for Enforcement or Granted as an Affirmative Defense is Ill-advised**

TMA, once again, expressly opposes the drafting note that appears in Section 4 of the Model Act. A state legislative body and state agencies should not rely on accreditation by a nationally recognized private entity as a substitute to statutory requirements and regulatory oversight. To accept certification as evidence of meeting the terms of this Act is an abrogation of responsibility to the public and is certainly not appropriate for statute.

As discussed on many calls the interest from CCIIO in potential regulation of network adequacy, the news story headlines – and likely complaints to your respective agencies – all demonstrate current regulatory frameworks regarding network adequacy are not working. In its July 2, 2014 letter to the NAIC upon the Model Act, the NCQA states, “We estimate that roughly 85% Marketplace/Exchange qualified health plans (QHPs) are, or are in process to be, NCQA accredited. Our network adequacy criteria – explained below – are often used to supplement state
reviews. In some cases states use our network adequacy requirements in place of their own. We believe revisions to the Model Act should sustain the important and flexible partnership ....”

Clearly (again based on complaints and headlines) it is highly likely that some certified entities (if the 85% marketplace penetration is presumed) at this moment have inadequate networks. Blue Shield of California in response to the California Department’s report outlining multiple deficiencies raised its “ongoing maintenance of the provider files for its Provider Directory. A provider demographic data validation is conducted for all network providers to comply with NCQA standards.”

Despite those standards the results of the “survey raise concerns to the Department regarding the accuracy of the Provider Directories available to the public.”

This seems to indicate that despite Blue Shield of California complying with NCQA standards there was a problem with, at least, directory accuracy.

The NCQA is a private, 501(c)(3) not-for-profit organization. It offers to health carriers and others the use of the NCQA seal in marketing when its accreditations requirements are met. It is not answerable to the public and is certainly not bound by the terms of the Texas Administrative Procedure Act (or any state APA). It is a private vendor answerable to its customers – in this circumstance health carriers. Private companies can modify their compliance standards at any time. Indeed, the NCQA is currently revising its network standards. Should a current statute refer to accreditation by private accrediting entity these proposed changes would profoundly modify the meaning of the statute. One may hope for the best, but there is no assurance the standards adopted will offer any increased protection. Certainly, there is no ongoing compliance monitoring in relation to certification (which is merely a “snap shot” approval, at best). TMA argues against adoption of the drafting note.

IV. Network Adequacy Standards Must be Disclosed

As stated in TMA’s previous letter, TMA supports the adoption by a legislature or department (through regulation) of a single network adequacy standard within a particular state and TMA reiterates and incorporates by reference its previous comments.

A review of the correspondence submitted to the Commissioners for consideration in the revision of the Network Adequacy Model Act reveals that those who represent health carriers request network adequacy standards that are “flexible” to “allow health plans to balance access … with affordability and quality.”

Essentially, this is a demand for a Laissez-faire approach to the regulation of insurance networks - a plea to entrench a “let them do as they will” enforcement philosophy in the new Model Act. TMA asserts that if the workgroup members ultimately adopt this approach, there will be no appreciable beneficial modification in health carrier marketplace conduct.

Headline after headline have appeared since the beginning of last year demonstrating how the health insurance industry has shirked the responsibility it has to the well-being of its customers and obligations owed to regulators.

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12 California Department of Managed Health Care Blue Shield of California Final Report of the Non-routine Survey, Page 10.
13 July 3, 2014 letter from the Blue Cross Blue Shield Association to Mr. J.P. Wieske, Chair, Network Adequacy Model Review (B) Subgroup. (emphasis added).
Even worse, many foundations and societies devoted to the care and cure of particular diseases or persons suffering from those diseases have discovered severe inadequacies in health carrier networks. For instance, the Leukemia and Lymphoma Society in a January 2014 report discovered that, in Texas, six health carrier QHPs did not have a single NCI Designated Cancer Center nor a single transplant center in network.\(^{15}\)

To continue as before is, respectfully, not an option. According to Jim O’Connor, an actuary with Milliman, “Narrow networks are sometimes used as substitutes for the old underwriting tools.”\(^{16}\)

One special issue. Following the submission of the TMA comment letter, the BCBS Association submitted comments with the following suggestion: “health plans need the flexibility to develop workable policies to designate an out-of-network provider as an in-network provider when a consumer’s extraordinary circumstances prevent treatment by an in-network provider.”\(^{17}\) TMA asserts that such arguments are actually merely attempts to encourage regulators to enable the inadequate networks that already exist. TMA again urges the development/recommendation of criteria from which legislators (or insurance department commissioners) may choose.

V. Inadequate Network – Process for Consumer Protection

Section 5.C.1. of the Model Act contains a provision intended to serve the protection/process that is contingent upon a general inadequacy of the network or a particular inadequacy of the network where a needed specialty is “not available to provide the covered benefit.” The proposed language in the draft is not precise enough to provide certainty in how insurers would implement this statutory command.

TMA recommends that the NAIC workgroup undertake the approach that Texas and California (in the Commissioner of Insurance’s recent emergency rulemaking) have taken in regard to ensuring consumers receive the full benefit of the network product they have purchased. That approach places health carriers on notice that an inadequate network may result in the plan paying full billed charges.

In regard to closed network products, the Texas Department of Insurance has maintained the coverage requirements of the Texas Code requires full settlement outstanding medical debts.

Specifically, the Department has stated that usual and customary or agreed upon rates that must be paid in circumstances where the network is inadequate may equate to a physician’s full billed charge, if necessary to hold the HMO enrollee harmless. In the Texas Department’s Biennial Report to the 80th Legislature, the Texas Department stated as follows:

… Further, because of the statutory directive to HMOs to “fully” reimburse the providers needed to fill network gaps at an agreed upon or usual and customary rate,

\(^{15}\)See, 2014 Individual Exchange Policies in Four States: An Early Look for Patients with Blood Cancer, page 21, available at:
http://www.lls.org/content/nationalcontent/pdf/ways/Milliman2014IndividualExchangePoliciesinFourStates_20140109.pdf


\(^{17}\)Blue Cross Blue Shield Association Letter to Mr. J.P. Wieske, pg. 2.
the providers, almost exclusively hospital-based, can require payment of full billed charges, an amount that often exceeds typical contract rates.\textsuperscript{18}

In California, Commissioner Dave Jones has just adopted emergency regulations intended to address misleading directories and the patient harm that results from inadequate networks. In his order, Commissioner Jones enters a finding that inadequate networks are “resulting in consumers being faced with financially devastating unanticipated, uncovered expenses, or worse – lack of access to timely medical care . . .”

To provide protection from inadequate networks and place health carriers on notice of their obligations to consumers, the emergency rules state:

\begin{enumerate}
\item[(d)] The insurer shall ensure that the covered persons obtain all covered services in the alternate access delivery system at no greater cost to the covered persons that if the services were obtained from network providers or facilities or shall make arrangements acceptable to the commissioner.
\item[(1)] Coinsurance, copayments and deductible requirements shall apply to alternate access delivery systems at the same level they are applied to in-network services.
\item[(2)] The alternate access delivery system may result in the insurer payment of billed charges to ensure network access.\textsuperscript{19}
\end{enumerate}

Members of the workgroup will want to note that this emergency regulation uses language currently contained within this very section of the Exposure Draft Model Act.

In keeping with these two state approaches, one which addresses closed networks and the other which addresses open networks, TMA offers the following substitute for Section 5.C.1. which captures the intent California regulation:

\begin{enumerate}
\item[C.(1)] When a covered service is not available through a preferred provider or there is an insufficient number or type of participating provider available to provide a covered service:
\item[(a)] a health carrier:
\item[(i)] shall ensure that co-insurance requirements are applied at the in-network percentage level;
\item[(ii)] shall ensure that copayment and deductible requirements are applied as in-network coverage; and
\item[(iii)] may be required to pay billed charges to ensure network access; or
\item[(b)] a health carrier shall make arrangements acceptable to the Commissioner.
\end{enumerate}

TMA has removed, from the exposure draft’s language the predicate that the health carrier “has determined it does not have a type” of provider as including that language leaves the consumer protection available only upon the carrier’s own determination. The consumer protection should trigger on the existence of an inadequate network, not industry determinations. Also, rather than discuss “processes,” as put forward by the exposure draft, TMA argues that duties that are placed

\textsuperscript{18} Biennial Report of the Texas Department of Insurance to the 80\textsuperscript{a} Legislature, December 2006, Mike Geeslin, Commissioner of Insurance; available at http://www.tdi.texas.gov/reports/documents/finalbie07.pdf

\textsuperscript{19} New §2240.7. Discretionary Waiver of Network Access Standards. Emergency Regulation Adopted January 5, 2015 (emphasis added).
upon carriers should require action on their part rather than merely mandating planning and processes. The TMA language above is intended to achieve that result.

VI. **Should the Model Act Apply to Closed Plans?**

One member of the workgroup solicited stakeholder input into whether this Act should apply to closed plans. TMA would encourage the inclusion (or continued inclusion from the original model) of closed plans in this exposure draft. Health Maintenance Organizations and Exclusive Provider Organizations are all network benefit plans with no out-of-network coverage. These closed plan types may gain popularity and are offered in the Health Insurance Marketplaces/Exchanges. Consumers who purchase these closed network health benefit plans should *at least* have the same (if not more) protections offered to “open plan” product consumers.

VII. **Closing**

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact me or the following staff of the Texas Medical Association: Kelly Walla, JD, LLM, TMA Deputy General Counsel; Patricia Kolodzey, TMA Associate Director, Legislative Affairs; or Warren Cooper, TMA Director of Healthcare Delivery Systems; at TMA’s main number 512-370-1300.

Sincerely,

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Vice President, Medical Economics  
Texas Medical Association