

**Report
Of the Health Network Adequacy Advisory
Committee**

**Senate Bill 1731, Section 11
Eightieth Legislature, Regular Session, 2007**



**Submitted by the
Texas Department of Insurance**

January 2009

TABLE OF CONTENTS

Executive Summary	3
Overview	4
Advisory Committee Members	7
Background Information	8
Key Issues Identified by Advisory Committee	13
Data Collection	17
Preliminary Health Plan Data Results	21
Hospital Survey of Facility-Based Physicians	29
Addendum – Stakeholder Position Papers	35
Texas Hospital Association	36
Texas Medical Association	38
Texas Association of Health Plans	42
Other States’ Activities	46

EXECUTIVE SUMMARY

The 80th Texas Legislature authorized the creation of the Health Network Adequacy Advisory Committee for the purpose of studying facility-based provider network adequacy of health benefit plans. The Committee is required to work with the Texas Department of Insurance (TDI) to develop requirements for health plan reporting on the use of non-network providers by health benefit plan enrollees and the payments made to those providers. This report is a summary of the activities and findings of the Committee as required under Senate Bill 1731. A supplemental report will be issued in early 2009 to include additional information based on health plan data and information that will be collected by TDI under rules adopted pursuant to SB 1731.

The issue of network adequacy and the financial implications on consumers who receive care from out-of-network providers has been the subject of lengthy debate and discussion throughout the country. Although a variety of approaches and remedies have been discussed and, in some cases, tried, the solution to this complex problem is not simple. The contract negotiations that occur between health plans and providers are complicated and sometimes contentious and reflect the disparate business needs of the two parties. While this report does not provide or recommend a solution for this growing business problem, the data and information reviewed by the Committee does provide several interesting findings and provides some of the first concrete data on the scope of the problem. Following is a brief summary of several key findings based on preliminary data reviewed by the Committee.

- Ninety percent of the total facility-based provider claims/visits reported by five of the largest preferred provider benefit plans (PPBPs) and 85 percent of claims/visits provided by health maintenance organizations (HMOs) indicate services were delivered by in-network facility-based physicians.
- Payment averages by health plans for both contracted and non-contracted providers varied, but one health plan in particular had average payment rates that are significantly lower for all types of providers compared to all other plans.
- Among PPBPs, four of the five plans generally report higher allowable payments for non-contracted providers than those reported for contracted physicians. One plan differs dramatically, often reporting non-contract allowables significantly lower than those for contract providers. In some cases, the health plan's payment to the provider will be less than the allowable amount due to insured cost-sharing requirements.
- Compared to PPBPs, HMOs reported significantly lower non-network claims paid.
- The extent to which hospitals attempt to coordinate patient care to ensure patients receive services from an in-network provider when possible is extremely limited; most hospitals are unable to coordinate such services due to scheduling issues and limited computer capabilities.
- Of all facility-based providers, emergency services represent the highest potential for balance billing in claims not paid by PPBPs, followed by anesthesiology and radiological services (data based on billed charges submitted by providers and allowed amounts paid by health plans). Based on data provided by the surveyed PPBPs, the total potential cost

of balance billed services was \$24,468,977 (based on total billed charges of \$88,423,629 and total charges of \$55,955,552 allowed by health plans). These data do not include or reflect claims filed or benefits paid under self-funded benefit plans, which are excluded from state insurance regulation under the federal Employees Retirement and Income Security Act (ERISA).

As mentioned above, while this report does not include any recommendations, the Department of Insurance is considering several regulatory options to address issues identified and discussed by the Advisory Committee. The Department will continue to work closely with the Legislature as we develop a regulatory response to this problem.

OVERVIEW

In 2007, the 80th Texas Legislature enacted Senate Bill 1731, a comprehensive health care initiative that includes numerous provisions designed to address consumers' growing need for health care quality and cost information. The "Consumer Access to Health Care Information" legislation creates several new opportunities for consumers to obtain information on the cost of proposed health care services, allowing them to predict and budget for anticipated health care costs. The data and information provided as a result of the legislation will enable consumers to more accurately understand the benefits of different health plans, the variations and limitations that may affect access to health care services, the choices they have regarding health care services, and the financial impact of their decisions.

Several of the provisions in SB 1731 are intended to ensure patients enrolled in health plans are informed that they may be responsible for significantly higher costs if they receive care from a non-network provider. Hospitals are required to provide written disclosures to patients about financial obligations for care they receive from the facility, and must inform patients that they may receive care from facility-based physicians who are not included in the patient's health plan network. Upon request from a patient, hospitals and physicians also must provide estimates of the cost of care and must post information notices in conspicuous areas where patients are likely to see the information.

Health plans are also required to enhance the information they provide to enrollees concerning out-of-network financial implications. Like providers, they must provide cost estimates for proposed services, providing both the amount the health plan expects to pay and the enrollee's responsibility. The health plan must also notify enrollees that they may receive care from non-network providers even when receiving treatment at an in-network facility. Notices must be included in an insurer's explanation of benefits, on the insurer's website, and in any listing of provider directories.

Although the initiatives will certainly improve the ability of insureds to better plan and prepare for their health care expenses, the Legislature also recognized that providing information is only one step towards addressing a complex problem. To further facilitate efforts to address balance billing and network adequacy concerns, SB 1731 also directed the Texas Department of Insurance (TDI) to appoint an advisory committee to study facility-based provider network adequacy of health benefit plans. Facility-based providers are

defined to include anesthesiologists, radiologists, pathologists, neonatologists, and emergency department physicians. The legislation specifies that the Committee must include an equal number of individuals representing physicians, hospitals and health benefit plans. The Committee is required to work with the Department to collect data from health benefit plans concerning the use of non-network providers by health benefit plan enrollees and the payments made to these providers.

This study is a summary of the preliminary results of the committee's effort to provide the information required under SB 1731. While the Committee has made significant progress over the past year, the Committee has not yet received the results of the data collection initiated under rules proposed by TDI. Because that data will not be available to the Committee until early 2009, a supplemental report will be issued to the Legislature to include the results of the health plan data call and any additional findings based on those survey results.

This report includes a background discussion of the current managed care market and how the varying regulations that address network adequacy and balance billing issues affect health maintenance organizations and preferred provider benefit plans, the providers who participate in those plans and the consumers who receive health care benefits. The report also includes a summary of some of the related issues discussed by the Committee and how the different stakeholders' perspectives vary. Also included is a detailed overview of the data provided to the Committee by health plans and hospitals. A brief summary of legislative and regulatory approaches used in other states is also provided.

Although the Committee considered at length a number of options that could be considered as recommendations to the Legislature, they were unable to reach a consensus on an approach that would be acceptable to both providers and health plans. As such, this report does not include any recommendations. It does, however, include some important data and information that the Committee believes will be useful as the Legislature considers future Legislative options. The Committee also points out that SB 1731 does not ask the Committee to propose recommendations or solutions, but is instructed to work with TDI to collect health plan data and complete a study of network adequacy. Although no solutions are offered, the Committee agrees that the opportunity to work with such an informed group of professionals has been extremely informative and has provided all members a better appreciation of the divergent perspectives and business challenges faced by providers and health plans.

While there are no recommendations, it is important to note that preliminary data provided to the Committee indicates that the incidence of non-network facility-based-provider claims is very limited among the five health plans that voluntarily submitted data to the Committee. The data provided by five of the state's largest preferred-provider health plans shows that 10 percent or fewer of their facility-based claims are out-of-network. The Committee recognizes that these data are preliminary and represent a limited segment of the insurance market. As such, the Committee will wait until the results of the official TDI data call are available before determining any final conclusions or suggestions.

ADDENDUM

Because the committee was unable to reach consensus on some key issues, the three committee stakeholder groups (physicians, hospitals and health plans) agreed to include with this report separate addendums that provide additional information on each group's unique perspective. The three addendums provided by the Texas Association of Health Plans, the Texas Hospital Association and the Texas Medical Association are drafted solely by those entities and the stakeholders they represent and were not edited or reviewed by TDI or the other stakeholders that serve on the Committee. **As such, please note that these documents are not consensus papers and should not be considered as representing the opinion of the Texas Department of Insurance or the Advisory Committee.**

ADVISORY COMMITTEE MEMBERS

The following individuals were appointed by the Commissioner of Insurance to serve as members of the Health Network Adequacy Advisory Committee:

Charles Bailey, Texas Hospital Association

Deborah Creath, M.D., East Texas Anesthesiology Association

David Cripe, Seton Health Care Network

Michael Deck, M.D., MD Pathology

Thomas Fletcher, M.D., Austin Radiological Association

Rick Haddock, Blue Cross and Blue Shield

Replaced by Brad Tucker, Blue Cross and Blue Shield

James Hickey, Wellpoint/Unicare

William Hinchey, M.D., President, Texas Medical Association

Donnie Hromadka, Humana

Clarence King, Aetna

Kathy Lee, Scott and White Memorial Hospital

John Lovelady, United Health Group

John Bruce Moskow, M.D., Emergency Service Partners

Jim Nelson, Attorney

Brittney Powlesson, Hospital Corporation of America

Brian Wallach, Cigna Healthcare

Jared Wolfe, Texas Association of Health Plans

BACKGROUND INFORMATION

The issues of network adequacy and balance billing have gradually emerged as serious concerns in recent years as the managed health care market has evolved to meet growing needs and as a result of efforts to address rising health care and health insurance costs. In Texas, more than 90 percent of citizens with private health insurance plans receive care through either a health maintenance organization (HMO) or Preferred Provider Benefit Plan (PPBP). (**Note:** Preferred Provider Benefit Plans are often referred to as a PPO, or preferred provider organization. Texas insurance law authorizes insurers to offer PPBPs, and health plans provide the care through a contracted network of providers which participate in the PPO. Insurance benefit plans are subject to state law and regulation but PPO networks are not. It should be noted that while PPBPs and PPOs are distinctly different, the term PPO is frequently used to refer to the PPBP offered by the health plan).

“Network adequacy” refers to a health plan’s ability to meet the medical needs of its enrollees by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all other health care services for which benefits are included under the terms of the health care contract. If an enrollee is unable to obtain services from an in-network health care provider and the health plan subsequently pays only a portion of the non-network provider’s charge, the patient may receive a bill for the balance of charges not paid by the health plan. In such cases, the patient is “balance billed.”

All states have struggled with the question of how to regulate health plan networks in a way that limits patients’ exposure to balance billing, but no single approach has evolved due, in part, to the variations in how states regulate their managed care industry. Although network adequacy and balance billing are technically two separate issues, they are directly related since inadequate networks will result in an increase in balance billing. Contracting for physician services has become an increasingly complex process that may vary according to the type of carrier issuing the plan, its size, the type of service rendered and the circumstances in which the service is provided. Other factors that will affect payment methodologies include the type of managed care model, the plan’s market share, the size of the physician practice and the benefits that practice brings to a network, and the health plan’s need for those particular services.

Although state law does address the adequacy of health care networks, their ability to provide services to enrollees, and certain contract issues and payment arrangements, TDI’s oversight of reimbursement payment amounts and contracting negotiations is limited. In addition, HMOs and PPBPs are subject to different regulatory and statutory requirements. To better understand the complexities of these issues and how they work, a brief overview of the legal standards governing reimbursement by the two types of managed care systems and how they affect both network adequacy and balance billing is provided below.

Balance Billing and Network Adequacy – HMOs

In an HMO environment, balance billing should rarely occur. An HMO provides or arranges to provide covered services for enrollees on a prepaid basis through a network of physicians and providers. The enrollee pays only a scheduled charge for these services, usually a fixed co-payment. As long as the enrollee stays within the HMO network, no payment issues should arise. Providers that participate in the HMO network have agreed by contract to accept the HMO's reimbursement for services as full payment and should not "balance bill" patients for fees above what the HMO reimburses.

If an enrollee obtains services outside the network or if the enrollee receives services not covered by the HMO contract, the HMO is generally not obligated to pay for the treatment. Two exceptions to this rule exist: 1) if an HMO refers an enrollee out-of network because its network does not include the appropriate provider, and 2) if an enrollee receives emergency services.

While Texas law contains a number of requirements to ensure HMO networks are sufficiently staffed to meet the medical needs of all enrollees, networks may be inadequate for a number of reasons. In some cases, there may be a lack of sufficient specialty providers with which to contract. In other situations, the HMO and providers may be unable to agree to contractual terms. In such instances, Texas law *guarantees* adequate coverage, requiring HMOs without a sufficient network to provide medically necessary services through an out-of-network referral. The HMO must fully reimburse the non-network provider at the usual and customary rate or at an agreed rate. This provision anticipates the parties will agree to payment terms before services are provided. The advance nature of the agreement should prevent balance billing.

However, there are instances in which there is not an opportunity for agreement to be reached between the HMO and a non-network provider concerning payment terms prior to the delivery of services, and balance billing may occur. This type of situation most often occurs with facility-based providers, such as radiologists, anesthesiologists, pathologists, emergency room physicians and neonatologists. Although an enrollee may choose an in-network hospital and surgeon, they may receive services from non-network providers while hospitalized. This occurs because hospitals contract with both providers and health plans, but health plans and providers have no contract. After the service has been performed, the HMO and the provider may disagree on the amount of payment and the provider may seek to recover payment from the enrollee to make up the difference. In this case, the enrollee did everything reasonably necessary to receive care through the network and should not be expected to pay an amount other than the co-payment or deductible required under their health plan contract. The HMO is required to fully reimburse the provider at the usual and customary or an agreed rate and the enrollee is not responsible for payment of a balance bill.

Emergency Services

Under the HMO Act, Texas law requires an HMO to reimburse emergency services providers at the usual and customary rate or an agreed rate. The emergency services provision does not include the term “fully” as does the out-of-network referral statute. Nonetheless, the Department interprets the statute to require that an HMO enrollee should not be responsible for payment of a balance bill. This is important to note because HMOs typically offer benefits through a closed network and have, therefore, always been more regulated than PPBPs. Since 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 requires 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.

Balance Billing and Network Adequacy – Preferred Provider Benefit Plans

Standards regarding network adequacy within PPBPs are more complicated than with HMOs since PPBPs do not provide prepaid care and benefits are included for non-network providers. Due to the fact that PPBPs include coverage for both in-network and out-of-network benefits, reimbursement issues under PPBPs are also more complex than in an HMO environment.

Reimbursement Calculations

Insurers reimburse PPBP benefits at two levels: 1) preferred provider (contracted) and basic (non-contracted). An insurer may pay a different (higher) level of benefits to an insured based on the insured’s selection of an in-network provider. Generally this is calculated on a coinsurance percentage basis; a plan might, for example, reimburse at 90 percent for in-network care and at 60 percent for out-of-network care.

The second and more varied factor is the reimbursement amount and the underlying figure on which the coinsurance percentage is based. Texas law contains no specific standard or guideline, such as “usual and customary” or “usual and reasonable,” by which to calculate or regulate this payment amount. The only legal restriction is that an insurer offering a PPBP shall ensure that both preferred provider benefits and basic level benefits are *reasonably available* to all insureds within a designated service area. While Texas law does impose certain responsibilities upon insurers to ensure premiums are reasonable and payments to providers and insureds are made promptly, fairly and in compliance with the insurance contract, Texas law does not generally require PPBPs to make publicly available the methodology or the data a company uses to determine their usual and customary or usual reasonable payment level. The one exception is a provision in Texas Insurance Code §1453.002 that allows out-of-network physicians to request from a health plan a written description of the factors the health plan considered in determining the provider’s

reimbursement rate. Generally, health plans do not disclose the actual data used to determine the payment rate as the law also states that a health plan is not required to disclose certain proprietary information.

Reimbursement calculation variations are best illustrated by the following examples that describe alternative reimbursement arrangements under a PPBP. For care within the network, assume an insured sees a primary care doctor who advises the insured to see a specialist. The following table shows the possible benefit scenarios the insured may encounter when seeing the specialist, depending on how the health plan calculates the payment rate. To see an in-network specialist, the enrollee would pay \$30 (in-network example). However, if the enrollee is treated by a non-network specialist, the enrollee’s financial responsibility could range from \$60 (example 1) up to \$172 (example 4).

Example of Variations in Health Plan Reimbursement Rating Calculations

In-Network Example: Preferred Provider Benefits Paid at 80% of Provider Contracted Rate	
Contracted Rate	\$150
80% Insurer Reimbursement	\$120
Enrollee Responsibility	\$30
Out of Network Example 1: Provider Bills at In-Network Rate	
Billed at Contracted Rate	\$150
60% Insurer Reimbursement Rate*	\$90
Enrollee Responsibility	\$60
Out of Network Example 2: Insurer Reimbursement Based on Billed Charges	
Billed Charges at Non-Contracted Rate	\$250
60% Insurer Reimbursement Rate*	\$150
Enrollee Responsibility	\$100
Out of Network Example 3: Insurer and Provider A Disagree on Charge Amount	
Billed Charges at Non-Contracted Rate	\$250
60% Insurer Reimbursement Based on Insurer’s Determination of Usual Charge of \$170*	\$102
Enrollee’s Responsibility	\$148
Out of Network Example 4: Insurer and Provider B Disagree on Charge Amount (for the Same Service as Provider A, above)	
Billed Charges at Non-Contracted Rate	\$250
60% Insurer Reimbursement Based on Insurer’s Determination of usual Charge of \$130*	\$78
Enrollee’s Responsibility	\$172

**Note: the 60% reimbursement rate is chosen for illustration purposes only and is not intended to suggest that 60% is a typical or average reimbursement percentage. Determination of the reimbursement level is a function of the insurer and is not generally subject to state regulation.*

As this table illustrates, PPBPs reimburse under several different standards. “Usual and customary,” “reasonable and customary,” and “allowable amount” are but three of the common terms insurers use to describe the amount they will use to calculate reimbursement for a particular service. Fifty percent reimbursement for a particular out-of-network service

usually results in different payment amounts from one insurer to another due to the fact that each plan will calculate their “reasonable and customary” or “allowable amount” differently. Although some balance billing is unavoidable and expected under PPBPs, the disparity between an insurer’s allowable amount and a provider’s billed charges may lead to unexpected and unpredictable financial costs for the insured who receives care from out-of-network providers.

The disparity in payments is particularly problematic when the insured has no choice but to obtain care outside the network because the insurer’s network does not provide access to an in-network provider within a particular facility, even though in-network services may be available at other facilities. This issue raises questions regarding the standard that should be used to determine whether a network is adequate and points out the relationship between network adequacy and balance billing. Both statutory and regulatory provisions that govern the oversight of HMOs and PPBPs are significantly different due primarily to variations in the benefit structure of HMOs and PPBPs and the provision of out-of-network benefits under PPBPs that is not provided under HMO benefit plans. As described above under the HMO overview, the most common network adequacy questions arise when an insured is admitted to an in-network hospital and has no choice but to accept care from non-network providers (such as a radiologist, anesthesiologist, or pathologist) while in the hospital. Sometimes the health plan has contracts with certain providers in a hospital but not all, and certain providers in a hospital contract with certain health plans, but not all. These decisions may impact a patient’s access to an in-network provider at contracted facilities.

Emergency Services

The statutory language governing *emergency* care under a PPBP is slightly different than that governing out-of-network care. State law (Texas Insurance Code Section 1301.155) provides that if an insured cannot reasonably reach a preferred provider, the insurer shall provide reimbursement for specified emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider. Generally the Department interprets this language to mean the same *percentage* level of reimbursement. For example, if the PPBP reimburses at 80 percent of the contract rate for in-network emergency services, the plan must calculate the out-of-network emergency benefit at that same 80 percent level. However, as pointed out in the note following the table on page 9, the dollar amount (the “allowed amount”) against which this percentage is applied is determined by the insurer and is generally not subject to state oversight.

KEY ISSUES IDENTIFIED BY ADVISORY COMMITTEE

Over the course of several lengthy discussions regarding the underlying factors that affect a health plan's ability to build and maintain an adequate network, the Committee identified some key issues that underscore the challenges faced by both health plans and providers. Although all participants agree that the primary goal is to ensure consumers have access to appropriate medical care, complex and often conflicting business needs and incentives make it difficult to design solutions that are acceptable to all stakeholders.

Health plans and providers acknowledge that both have financial interests that strongly influence the decisions they make. Health plans point out that contracting with providers results in lower claims payments, which is passed on to consumers in the form of lower premium costs. Providers who agree to contract with a health plan network receive certain payment protections and guarantees under the state's prompt payment provisions and will generally receive faster payments from health plans and benefit from the volume of patients a health plan directs to in-network providers. The benefits of such patient "steerage" is intended to compensate for lower payments that providers agree to when they contract with a health plan.

These issues and other factors that impact contract negotiations and the development of health plan networks are discussed below. While these discussions are briefly summarized and are not intended to fully explore the scope of the problem, they do highlight some of the most common challenges and concerns raised by both providers and health plans.

- **Transparency of both provider costs and health plan payments are admirable goals but difficult to achieve due to the competitive nature of the health care industry.**

As was discussed in the report overview, transparency and the provision of information to help consumers make informed financial decisions is a primary goal of SB 1731. Committee members agree that while cost information is useful and increased transparency can be an effective tool, they disagree on the extent to which confidential information is required or necessary to achieve an appropriate level of disclosure.

Contracting for provider services often involves extensive negotiations. In order to reach an agreement that is acceptable to both the health plan and the providers, participants must agree on a number of contract provisions, but rate negotiations are usually the most contentious issue. Insurers use a variety of methodologies to develop their rate proposals, and the underlying data used to build those proposals is often not available to providers. As mentioned previously, current law (Texas Insurance Code §1453.002) does, however, provide that out-of-network physicians may request from a health plan a written description of the factors the health plan considered in determining the provider's

reimbursement rate. If a health plan denies a request for information, they are required to send a copy of the request and the information that was requested to TDI for review.

The provision of information, however, is no guarantee that providers and payers can reach agreement. Health plans, as explained above, are in a competitive position and want to negotiate the best price possible for services. Providers, on the other hand, will negotiate for the best contract rate possible for their services and report that they are in a competitive market environment as well. The facility-based physician has to carefully weigh the contract offer of the PPBP against their duty to provide services to all hospital patients, emergency room (ER), inpatient and outpatient, regardless of the payor or the patient's ability to pay. In some cases, their inability to reach agreement will mean the health plan is unable to provide access to in-network facility-based providers at an in-network hospital, raising questions regarding the adequacy of a health plan's network. Whether or not additional transparency will result in more successful contract negotiations is unknown.

Today, healthcare consumers desire and are expected to participate in making rational economic decisions about how to spend their healthcare dollar. To do so, patients need more information regarding their choice of providers and the costs of their health care in order to make responsible, informed decisions. Patients need to have easy access to reliable information from both providers and health plans regarding the anticipated cost of medical services, what the health plan will pay, and the patient's estimated financial responsibility. In today's electronic world, most health plans are able to provide timely information regarding the network status of providers before the services are rendered, which will help consumers determine the costs they will incur when they receive medical care. Consumers also need to understand the difference between in-network and non-network benefits provided under their benefit plan and how benefit payments for both types of services are determined. This information is important because it determines what amount of the physician's bill the insurance company will pay and what portion the patient will be responsible for. Since most healthcare plans are purchased by employers, clarity regarding the patient's financial responsibility and the methodology used by health plans to determine benefit payments must also be available to employers so they can carefully evaluate health care plan options for their employees. These transparency issues are vital pieces of the puzzle that patients need to make the best possible decisions for their healthcare.

- **Data reporting requirements under SB 1731 are limited to health plans.**

Comprehensive, accurate data is necessary for a complete, objective study of the factors affecting network adequacy. Collection and evaluation of data is the primary focus of the Committee's study. However, data reporting requirements under SB 1731 are limited to information provided by health plans. The Department of Insurance is required to enact rules collecting data from health plans, but no similar reporting requirement exists for either hospitals or physicians or the agencies that regulate those entities. While most, if not all, committee members agree that data from hospitals and physicians would be useful in conducting the study, TDI has no authority to require providers to submit

information. Further, the agencies licensing hospitals and providers lack the authority to collect such data.

While it is logical to collect health plan data since insurers maintain claims records that will help evaluate the extent to which patients obtain care from non-network providers and the cost of those services compared to in-network services, the data does not provide a complete picture of what occurs within the health care market. Numerous unanswered questions were raised regarding contracting practices and concerns of providers. The Committee developed a survey that was sent to a sample of Texas hospitals, but compliance with the survey request was completely voluntary. Although the legislation did not require data to be collected from physicians, who obviously will have a unique perspective in this study, the Texas Medical Association (TMA) volunteered to provide a summary of the 2008 Physician Survey results. The survey findings shared with the Committee focused on responses to questions related to facility based physicians' contracting practices of the various health plans. Additional information on this survey is included in the TMA addendum attached to this report.

- **The extent to which balance billing actually occurs is impossible to determine.**

Health plan claims information will provide data on the total value of unreimbursed out-of-network services that could be subject to balance billing. However, both hospitals and providers participating on the Committee indicate that consumers are not always billed for remaining balances. In the absence of any information from providers, it is impossible to accurately determine how often or under what circumstances a provider will balance-bill a patient.

- **Hospitals, health plans, providers and consumers are challenged to provide or obtain current lists of in-network providers due to the absence of a centralized data base that maintains a current listing of facility-based physicians.**

Health plans are required under SB 1731 to provide consumers with accurate directories that include a listing of in-network providers, including physicians and facilities. The plans also must maintain and provide information on in-network hospitals that contract with non-network facility-based providers so consumers can make informed decisions about the potential financial impact if they select a facility where they are likely to receive care from non-network providers.

While health plans know the providers with whom they contract, they do not always have accurate information on the providers with whom the hospital contracts, particularly when hospitals change providers without notifying the health plans. With more than 400 hospitals across the state, contract negotiations and changes occur on a daily basis. Some providers may be dropped from a network or may lose hospital privileges while others may be added. Hospitals usually are not obligated to inform a health plan when new providers are added or existing contracts are terminated or not renewed.

Inaccurate provider directories and health plan materials affect all stakeholders. Consumers may choose a provider based on an outdated directory only to find that the provider is not within the health plan's network. Providers may refer a patient to a specialist or facility only to find out the provider or facility is no longer in the patient's network. Both situations create the potential for delayed health care services and expose patients to the potential of out-of-network charges that could have been avoided if the consumer was provided accurate information. Every day, consumers make important decisions regarding their health care based on the listing of providers that health plans are required to maintain. It is extremely important to ensure those lists are current and accurate for both financial and medical reasons.

- **Exclusive provider arrangements may enhance or restrict access to in-network services.**

Both hospitals and health plans enter into "exclusive provider" contracts that limit the ability of other providers to provide services which could impact and may affect the ability of health plans to maintain adequate networks. Hospitals may agree to use the services of one single physician practice group for a particular type of facility-based services, such as radiology or emergency services. No provider outside that practice group will be allowed to provide those services within the hospital.

Both hospitals and health plans report that these exclusive provider arrangements are business decisions that are made for a variety of reasons. Hospitals representatives on the Committee report that some hospitals encourage their contracted providers to also contract with their in-network health plans to avoid situations where patients must receive care from non-network providers.

While the Committee is not issuing any recommendations regarding this practice, it does acknowledge that the use of exclusive providers agreements is a complex business decision that may impact consumers. For more information on this issue and an overview of the different perspectives on the value of such agreements, please see the stakeholder addendums attached to this report.

- **A hospital's ability to coordinate patient care to assign in-network physicians to a specific patient is limited.**

In many cases, a hospital contracts with numerous facility-based providers, many of whom participate in some health plan networks but not all. One way of reducing the chances that a patient will receive care from a non-network facility based provider is for the hospital to coordinate a patient's treatment, assigning in-network providers to that patient. For example, if a patient is scheduled for surgery and 10 of the hospital's 15 anesthesiologists are also contracted providers with the patient's health plan, the hospital could assign one of the 10 in-network anesthesiologists to that patient.

While this approach may sound logical and relatively simple, hospital, health plan, and physician representatives on the Advisory Committee reported that most hospital systems are simply unable to schedule services in a way that would ensure a patient receives treatment from an in-network provider when possible. This is partly due to technological scheduling limitations, but is also due to the fact that providers' schedules may change without notice. Hospitals may be unable to predict when a particular provider may be available and are reluctant to make assignments based primarily on whether a provider is in a patient's health plan network. In other situations, a surgeon may request a specific provider based on that doctor's expertise. Those types of requests may not accommodate a patient's preference for an in-network anesthesiologist.

DATA COLLECTION

Senate Bill 1731 directs the Committee to collect and evaluate data on network adequacy and the use of non-network providers in order to better understand and define the scope of the problem and the extent to which consumers may be adversely affected. The legislation recognizes that data and information are critical tools for developing objective solutions based on factual rather than anecdotal data.

The Committee carefully considered the types of data and information that would be helpful in evaluating the problems of network adequacy and balance billing by first identifying a series of questions they would like to be able to answer, including:

- What is the number and percentage of patients who received treatment from non-network facility based providers at in-network facilities?
- What is the total cost of claims for non-network providers compared to in-network providers?
- Does the incidence rate of out-of-network services vary by type of provider?
- Does the incidence rate of out-of-network services vary by health plan?
- What is the difference in claims payments for in-network services compared to out-of-network services, and to what extent do those payments vary by health plans?
- What are the primary reasons why health plans are unable to contract with facility based providers?
- What is the association between health plans' payment rates and the utilization of non-network services?
- What role does the hospital play in the decision to contract with some providers and not others?
- To what extent do hospitals attempt to coordinate their contracts to ensure the facility-based providers with whom they contract are also contracted providers with the hospital's contracted health plans?
- To what extent do non-network providers balance bill patients when the health plan's payment and patient's coinsurance requirements are insufficient to cover the full billed amount?

SB 1731 requires TDI to collect data from **health plans** on the use of non-network providers and the claims amounts paid to those providers. While many of the questions above can be at least partially answered using claims data maintained by health plans, other questions are directed towards providers and cannot be answered by health plan data alone. The Legislation does not, however, impose reporting requirements on providers and the Department has no authority to compel hospitals or providers to respond to a request for information, nor does any agency. In order to present data that more broadly represents the experience of both providers and health plans, the Committee considered various options for collecting data from physicians and hospitals.

After discussing the logistics that would be involved in requesting data from providers, the Committee determined that a physician survey would not be realistic given the large number of providers. Several of the physicians on the Committee pointed out that the level of information maintained by individual physician practices varies widely and is unlikely to be available in a uniform manner that could easily be retrieved and reported to the Committee. As such, no request for information was sent to the physician community.

The Committee did, however, agree that most hospitals would be in a position to provide valuable information on their contracting practices and how they address the coordination of services for patients for whom the hospital is a network provider, but who may receive services from non-network facility based providers while in the hospital. Included in this report is a summary of information provided from hospitals that responded to a survey drafted by the Committee and administered by TDI staff.

As required in SB1731, the Committee also worked diligently with the Department to develop health plan data reporting requirements that would address many of the questions listed above. Based on the Committee's recommendations, the Department drafted and published a proposed rule requiring HMOs and PPBPs to submit data that will be collected by the Department and provided to the Committee for additional review and consideration. The data will be available early next year and will be included in the Committee's supplemental report.

Health Plan Preliminary Claims Data

While in the process of drafting the recommendations to TDI for the health plan data collection proposal, the Committee identified several critical data elements that they believe are key to a better understanding of the network adequacy barriers and concerns and the prevalence of balance billing. Rather than wait for the results of the TDI data collection (which takes numerous months to complete due to the complexities and legalities of the rule proposal and adoption process), several health plans offered to voluntarily provide preliminary information for the committee's review. The collection and reporting of the health plan data was coordinated by the Texas Association of Health Plans (TAHP) and includes information provided by both HMOs and PPBPs.

A total of six large insurers provided detailed information on the number of in-network and non-network visits and/or claims paid by health plans for the facility based providers identified in SB 1731, including anesthesiologists, emergency room physicians, pathologists, radiologists, and neonatologists. Financial payment information is also provided, summarizing the total billed amounts, allowed amounts, and average claim costs based on allowed charges. Of the six health plans, all but one provided separate data for HMOs and PPBPs. The sixth company combined data for both types of business and is not included in this summary report since the data is not comparable to that provided by the other five health plans. For that reason, data on company “A” is not included.

Because the data submitted to the Committee did not include company identities, the information refers to health plans as B, C, D, E, F. The same identifier is used for both PPBPs and HMOs for each company’s submission. For purposes of this survey information, the following terms are used:

- **Total Billed Amount:** a sum of the total amounts billed by the providers for services provided to the patients.
- **Total Allowed Amount:** the total reimbursement amount a health plan allows as payable for the physician services provided; includes both the health plan’s payment and any applicable co-pays, deductibles, or co-insurance payments that the patient is responsible for.
- **Contracted Provider:** physicians or other medical service providers who have a contract with the health plan to participate as a network provider and agree to accept contracted allowed payment amounts as full payment for specific services.
- **Non-Contracted Provider:** physicians or other medical service providers who are not contracted with the health plan and have not agreed to a pre-negotiated payment amount for specific services; providers receive payments based on the health plan’s allowed amount and may require patients to pay the balance of any remaining charges not paid by the health plan.

The survey results for Preferred Provider Benefit Plans are provided first, followed by information provided by Health Maintenance Organizations. One plan (Plan E) provided information only for the PPBP; no data for Plan E is provided in the HMO summary tables.

Because this data is preliminary and does not reflect industry-wide experience, this report does not provide a detailed summary of the results. The survey does, however, provide some interesting information that verifies the complexities and wide variations among health plan payments and the extent to which non-network services are used by enrollees. Some observations include:

- Insurers’ allowable payment rates for both in-network and non-network providers vary significantly among health plans and by type of provider.

- Among all types of providers, emergency room physicians had the highest rate of out-of-network claims at 35 percent for both PPBPs and HMOs. One PPBP reported 89.9 percent of emergency claims were provided by non-network providers. However, it should be noted that this plan accounted for less than one percent of all emergency physician claims, which illustrates the fact that plans of different sizes may report wide variations in claim experience.
- Health plans' allowable payment amounts for both in-network and out-of-network services varied widely among plans and by type of providers.
- Health plan allowable amounts for non-contracted providers were consistently higher than average payments for contracted providers. Among PPBPs, four of the five plans generally report higher allowables for non-contracted providers than those reported for contracted physicians. One plan differs dramatically, often reporting non-contract allowables significantly lower than those for contract providers. In many cases, the actual payment amount will be less than the allowable amount due to the insured's financial coinsurance requirements.
- Based on preliminary data for non-contracted claims data submitted by five PPBPs, emergency services represent the highest potential for balance billing at \$12,116,183 in claims not paid by PPBPs, followed by anesthesiology at \$6,823,760 and radiological services at \$4,334,772 (data based on billed charges submitted by providers and allowed amounts paid by health plans). The total potential cost of balance billed services was \$24,468,977 (based on total billed charges of \$88,423,629 and total charges of \$55,955,552 allowed by health plans).
- Of the more than 1.9 million total claims reported by PPBPs, approximately 10 percent (215,062) were for out-of-network facility-based providers based on data reported by PPBPs. Health maintenance organizations reported a total of 439,245 claims, of which 15 percent (65,305) were submitted by non-network providers.

Following is a detailed summary of the data provided by the health benefit plans, followed by a summary of the hospital survey results.

A. Preferred Provider Benefit Plan Summary Data

**Table 1 – Number of Patient Claims for Contracted/Non-Contracted Providers
By Type of Provider**

Preferred Provider Benefit Plans

Provider Type and Plan ID	# of Claims For Contracted Providers	# of Claims for Non-Contracted	% Of Total Claims for Non-Contracted Provider Visits
Anesthesiology			
Plan B	16,308	7,582	31.7%
Plan C	4,602	2,761	37.5%
Plan D	18,480	1,748	8.6%
Plan E	146,322	7,802	5.1%
Plan F	1,536	361	19.0%
Total	187,248	20,254	10.8%
Emergency Room			
Plan B	17,241	10,330	37.5%
Plan C	3,113	3,358	51.9%
Plan D	22,329	4,798	17.8%
Plan E	90,340	54,551	37.7%
Plan F	104	928	89.9%
Total	133,127	73,965	35.7%
Neonatology			
Plan B	3,152	803	20.0%
Plan C	684	229	25.1%
Plan D	0	0	0
Plan E	21,047	55	0.3%
Plan F	127	324	71.8%
Total	25,010	1,411	5.4%
Pathology			
Plan B	88,788	14,274	13.8%
Plan C	18,589	3,470	15.7%
Plan D	15,850	404	2.5%
Plan E	435,190	12,547	2.8%
Plan F	15,263	3,314	17.8%
Total	573,680	34,009	5.6%
Radiology			
Plan B	82,606	17,252	17.3%
Plan C	160,053	55,246	25.7%
Plan D	53,925	3,416	6.0%
Plan E	526,086	7,436	1.4%
Plan F	9,823	2,073	17.4%
Total	832,493	85,423	9.3%

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Table 2 – Billed Amount of Claims Filed by Contracted and Non-Contracted Providers by Type of Provider

Preferred Provider Benefit Plans

Provider Type and Plan ID	Total Billed Amount Filed by Contracted Providers	Total Billed Amount Filed by Non-Contracted Providers	% Of Combined Total Billed Amount Filed by Non-Contracted Providers
Anesthesiology			
Plan B	\$20,631,752	\$10,367,137	33.4%
Plan C	\$5,002,782	\$2,693,907	35.0%
Plan D	\$20,849,897	\$1,679,170	7.5%
Plan E	\$161,977,859	\$9,740,125	5.7%
Plan F	\$1,166,862	\$400,669	25.6%
Total	\$209,629,152	\$24,887,008	10.6%
Emergency Room			
Plan B	\$7,099,156	\$4,612,663	39.3%
Plan C	\$1,006,350	\$1,243,437	55.3%
Plan D	\$8,432,106	\$1,924,868	18.6%
Plan E	\$33,678,949	\$26,802,308	44.3%
Plan F	\$13,473	\$284,916	95.4%
Total	\$50,230,034	\$34,868,192	41.0%
Neonatology			
Plan B	\$2,730,813	\$741,789	21.4%
Plan C	\$709,235	\$160,505	18.5%
Plan D	\$0	\$0	0
Plan E	\$24,644,697	\$39,548	0.2%
Plan F	\$63,659	\$268,505	80.8%
Total	\$28,148,404	\$1,210,347	4.1%
Pathology			
Plan B	\$13,025,459	\$1,781,077	12.0%
Plan C	\$2,388,798	\$381,517	13.8%
Plan D	\$5,579,836	\$126,867	2.2%
Plan E	\$69,363,164	\$1,283,823	1.8%
Plan F	\$570,449	\$151,927	21.0%
Total	\$90,927,706	\$3,725,211	4.0%
Radiology			
Plan B	\$17,310,621	\$3,535,591	17.0%
Plan C	\$25,397,131	\$9,790,514	27.8%
Plan D	\$10,720,868	\$791,614	6.9%
Plan E	\$99,027,382	\$1,340,990	1.3%
Plan F	\$1,228,207	\$280,162	18.6%
Total	\$153,684,209	\$15,738,871	9.3%

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Table 3 – Total Allowed Amount Paid by Health Plans to Contracted and Non-Contracted Providers by Type of Provider

Preferred Provider Benefit Plans

Provider Type and Plan ID	Total Allowed Amount For Contracted Providers	Total Allowed Amount For Non-Contracted Providers	% Of Combined Total Allowed Amount Paid to Non-Contracted Providers
Anesthesiology			
Plan B	\$11,324,184	\$,9657,479	46.0%
Plan C	\$3,320,708	\$2,428,834	42.2%
Plan D	\$14,189,958	\$1,427,294	9.1%
Plan E	\$72,563,325	\$4,227,060	5.5%
Plan F	\$839,894	\$316,581	27.4%
Total	\$102,238,069	\$18,057,248	15.0%
Emergency Room			
Plan B	\$3,920,925	\$4,280,886	52.2%
Plan C	\$690,036	\$1,108,202	61.6%
Plan D	\$6,175,838	\$1,592,239	20.5%
Plan E	\$14,422,444	\$15,641,198	52.0%
Plan F	\$6,601	\$129,484	95.1%
Total	\$25,215,844	\$22,752,009	47.43%
Neonatology			
Plan B	\$2,247,770	\$661,315	22.8%
Plan C	\$585,866	\$124,055	17.5%
Plan D	\$0	\$0	0
Plan E	\$14,580,628	\$15,268	0.1%
Plan F	\$43,095	\$198,788	82.2%
Total	\$17,457,359	\$999,426	5.4%
Pathology			
Plan B	\$7,844,350	\$1,693,829	17.8%
Plan C	\$1,402,544	\$314,122	18.3%
Plan D	\$2,968,063	\$99,376	3.2%
Plan E	\$36,513,356	\$523,586	1.4%
Plan F	\$242,379	\$111,857	31.6%
Total	\$48,970,692	\$2,742,770	5.3%
Radiology			
Plan B	\$8,759,759	\$3,359,171	27.7%
Plan C	\$14,660,801	\$6,796,189	31.7%
Plan D	\$5,685,626	\$552,194	8.8%
Plan E	\$39,054,768	\$519,310	1.3%
Plan F	\$508,038	\$177,235	25.9%
Total	\$68,668,992	\$11,404,099	14.2%

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Table 4 – Percentage of Billed Amount That is Determined to be Allowable by Health Plans and Avg. Allowed Amount Per Visit/Claim for Contracted and Non Contracted Providers by Provider Type

Preferred Provider Benefit Plans

Provider Type and Plan ID	Percentage of Total Billed Amount Allowed by Payers for Contracted Providers	Percentage of Total Billed Amount Allowed by Payers for Non-Contracted Providers	Avg. Total Allowed Amount Per Claim/Visit for Contracted Providers	Avg. Total Allowed Amount Per Claim/Visit for Non-Contracted Providers
Anesthesiology				
Plan B	54.9%	93.2%	\$694	\$1,274
Plan C	66.3%	90.1%	\$722	\$880
Plan D	68.0%	85.0%	\$767	\$816
Plan E	44.8%	43.4%	\$495	\$541
Plan F	72.0%	79.0%	\$547	\$877
Total	48.8%	72.5%	*\$645	*\$878
Emergency Room				
Plan B	55.2%	92.8%	\$227	\$414
Plan C	68.6%	89.1%	\$222	\$330
Plan D	73.2%	82.7%	\$276	\$331
Plan E	42.8%	58.4%	\$159	\$286
Plan F	49.0%	55.4%	\$63	\$140
Total	50.2%	65.3%	*\$189	*\$300
Neonatology				
Plan B	82.3%	89.2%	\$713	\$824
Plan C	82.6%	77.3%	\$857	\$542
Plan D	0	0	\$0	\$0
Plan E	59.1%	38.6%	\$692	\$277
Plan F	67.7%	74.0%	\$339	\$614
Total	62.0%	82.6%	*\$650	*\$564
Pathology				
Plan B	60.2%	95.1%	\$88	\$119
Plan C	58.7%	82.3%	\$75	\$91
Plan D	53.2%	78.3%	\$187	\$245
Plan E	52.6%	40.8%	\$83	\$41
Plan F	42.5%	73.6%	\$16	\$34
Total	53.8%	73.6%	*\$90	*\$106
Radiology				
Plan B	50.6%	95.0%	\$106	\$195
Plan C	57.5%	69.4%	\$92	\$123
Plan D	53.0%	69.8%	\$105	\$161
Plan E	39.4%	38.7%	\$74	\$69
Plan F	41.4%	63.2%	\$52	\$85
Total	44.7%	63.3%	*\$86	*\$127

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

*Total avg. reported is per-health plan and is not based on total aggregated claims

THIS IS PRELIMINARY DATA.: MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Health Maintenance Organization Summary Data

**Table 5 – Number of Patient Claims for Contracted/Non-Contracted Providers
By Type of Provider**

Plan ID	# of Claims For Contracted Providers	# of Claims for Non-Contracted	% Of Total Claims for Non-Contracted Provider Visits
Anesthesiology			
Plan B	11,526	4,886	29.7%
Plan C	7,234	3,266	31.1%
Plan D	7,178	904	11.1%
Plan F	6,962	506	6.7%
Total	32,900	9,562	22.5%
Emergency Room			
Plan B	17,564	7,885	30.9%
Plan C	5,998	7,902	56.8%
Plan D	10,772	1,168	9.7%
Plan F	847	2,092	71.1%
Total	35,131	10,047	35.1%
Neonatology			
Plan B	4,458	1,814	28.9%
Plan C	2,636	302	10.2%
Plan D	0	0	
Plan F	1366	319	18.9%
Total	8,460	2,435	22.3%
Pathology			
Plan B	59,019	5,109	7.9%
Plan C	19,059	5,654	22.8%
Plan D	10,170	2,765	21.3%
Plan F	53,649	6,156	10.2%
Total	141,897	19,684	12.1%
Radiology			
Plan B	56,429	7,477	11.6%
Plan C	28,123	10,885	27.9%
Plan D	23,333	1,319	5.3%
Plan F	47,667	3,896	7.5%
Total	155,552	23,577	13.1%

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Table 6 – Billed Amount of Claims Filed by Contracted and Non-Contracted Providers by Type of Provider

Health Maintenance Organizations

Plan ID	Total Billed Amount Filed by Contracted Providers	Total Billed Amount Filed by Non-Contracted Providers	% Of Combined Total Billed Amount Filed by Non-Contracted Providers
Anesthesiology			
Plan B	\$14,440,555	\$6,570,328	31.2%
Plan C	\$9,003,677	\$4,221,928	31.9%
Plan D	\$7,875,550	\$825,286	9.4%
Plan F	\$5,597,046	\$544,474	8.8%
Total	\$36,916,828	\$12,162,016	24.7%
Emergency Room			
Plan B	\$6,960,900	\$3,412,683	32.8%
Plan C	\$1,859,314	\$2,545,592	57.7%
Plan D	\$3,783,027	\$411,610	9.8%
Plan F	\$957,654	\$642,861	40.1%
Total	\$12,728,243	\$7,012,746	35.5%
Neonatology			
Plan B	\$3,588,073	\$1,575,610	30.5%
Plan C	\$3,437,642	\$320,403	8.5%
Plan D	\$0	\$0	
Plan F	\$957,654	\$223,909	18.9%
Total	\$7,983,369	\$2,119,922	20.9%
Pathology			
Plan B	\$8,186,827	\$747,494	8.3%
Plan C	\$1,830,609	\$471,580	20.4%
Plan D	\$2,461,729	\$361,846	12.8%
Plan F	\$2,180,039	\$197,715	8.3%
Total	\$14,659,204	\$1,778,635	10.8%
Radiology			
Plan B	\$10,597,300	\$1,448,131	12.0%
Plan C	\$4,006,408	\$1,792,988	30.9%
Plan D	\$4,331,128	\$287,308	6.2%
Plan F	\$5,757,016	\$490,246	7.8%
Total	\$24,691,852	\$4,018,673	13.9%

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Table 7 – Total Allowed Amount Paid by Health Plans to Contracted and Non-Contracted Providers by Type of Provider

Health Maintenance Organizations

Plan ID	Total Allowed Amount For Contracted Providers	Total Allowed Amount For Non-Contracted Providers	% Of Combined Total Allowed Amount Paid to Non-Contracted Providers
Anesthesiology			
Plan B	\$7,889,913	\$4,641,290	37.0%
Plan C	\$5,063,079	\$3,681,615	42.1%
Plan D	\$4,895,164	\$812,835	14.2%
Plan F	\$3,920,625	\$351,695	8.2%
Total	\$21,768,781	\$9,487,435	30.3%
Emergency Room			
Plan B	\$3,775,728	\$1,843,265	32.8%
Plan C	\$805,949	\$2,119,926	72.4%
Plan D	\$2,683,934	\$393,488	12.7%
Plan F	\$60,294	\$330,192	84.5%
Total	\$7,325,905	\$4,686,871	39.0%
Neonatology			
Plan B	\$2,634,539	\$808,780	23.4%
Plan C	\$2,779,349	\$269,297	8.8%
Plan D	\$0	\$0	
Plan F	\$493,055	\$125,226	20.2%
Total	\$5,906,942	\$1,203,303	16.9%
Pathology			
Plan B	\$5,116,585	\$339,953	6.2%
Plan C	\$1,167,475	\$397,093	25.3%
Plan D	\$1,138,849	\$352,889	23.6%
Plan F	\$905,770	\$112,862	11.0%
Total	\$8,328,679	\$1,202,797	12.6%
Radiology			
Plan B	\$5,599,984	\$822,749	12.8%
Plan C	\$2,761,892	\$1,471,866	34.7%
Plan D	\$2,085,278	\$262,950	11.1%
Plan F	\$2,344,845	\$258,450	9.9%
Total	\$12,791,999	\$2,816,015	18.0%

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Table 8 – Percentage of Billed Amount That is Determined to be Allowable and Avg. Allowed Amount Per Visit/Claim for Contracted and Non-Contracted Providers by Provider Type

Health Maintenance Organizations

Plan ID	Percentage of Total Billed Amount That is Allowed by Payers for Contracted Providers	Percentage of Total Billed Amount That is Allowed by Payers for Non-Contracted Providers	Avg. Total Cost Per Claim/Visit for Contracted Providers Based on Allowed Amounts	Avg. Total Per Claim/Visit for Non-Contracted Providers Based on Allowed Amounts
Anesthesiology				
Plan B	54.6%	70.6%	\$685	\$950
Plan C	56.2%	87.2%	\$700	\$1,127
Plan D	62.1%	98.4%	\$682	\$899
Plan F	70.0%	64.5%	\$563	\$695
Total	58.9%	78.0%	*\$657	*\$918
Emergency Room				
Plan B	54.2%	54.0%	\$215	\$234
Plan C	43.3%	83.2%	\$134	\$268
Plan D	70.9%	95.5%	\$249	\$337
Plan F	48.2%	51.3%	\$71	\$158
Total	57.5%	66.8%	*\$167	*\$249
Neonatology				
Plan B	73.4%	51.3%	\$591	\$446
Plan C	80.8%	84.0%	\$1,054	\$892
Plan D	0 claims	0 claims	0 claims	0 claims
Plan F	51.4%	55.9%	\$361	\$393
Total	73.9%	56.7%	*\$668	*\$577
Pathology				
Plan B	62.4%	45.4%	\$87	\$67
Plan C	63.7%	84.2%	\$61	\$70
Plan D	46.2%	97.5%	\$112	\$128
Plan F	41.5%	57.0%	\$17	\$18
Total	56.8%	67.6%	*\$69	*\$71
Radiology				
Plan B	52.8%	56.8%	\$99	\$110
Plan C	68.9%	82.0%	\$98	\$135
Plan D	48.1%	91.5%	\$89	\$199
Plan F	40.7%	52.7%	\$49	\$66
Total	51.8%	70.0%	*\$84	*\$127

Source: Data Provided Voluntarily by Five Health Plans Through the Texas Association of Health Plans; Identities of Health Plans Not Provided with Data Submission

*Total avg. reported is per-health plan and is not based on total aggregated claims

THIS IS PRELIMINARY DATA. MORE DETAILED AND COMPLETE INFORMATION WILL BE PROVIDED IN THE COMMITTEE'S SUPPLEMENTAL REPORT EARLY IN 2009.

Hospital Survey of Facility-based Physicians

Hospitals’ decisions regarding facility-based physician contracts are a key factor in determining whether a patient has access to an in-network physician. To better understand the role of hospitals, their contracting practices and the challenges they face as coordinators of patients’ health plan benefits, the Committee developed a brief survey that was mailed to a sample of Texas hospitals. The survey includes seven questions that address contracting activities, coordination of services for patients with managed care benefit plans, and the exchange of information between the hospitals, health plans and facility-based providers. The questions were designed to identify common industry practices and provided hospitals the opportunity to offer their perspective on these and other issues. Since the questions were posed in an open-ended manner in an effort to obtain more detailed information, TDI reviewed and categorized the responses into a summary report for the Committee’s review. Following is a summary of the information provided to the Advisory Committee.

Survey Results

TDI addressed the survey to the CEOs of all hospitals with over 100 beds and a random sampling of 25 percent of the hospitals with fewer than 100 beds. The sample size represented 289 hospitals of the total 604 in Texas (48 percent). For purposes of data analysis, hospitals were placed into three separate categories by size: small (1-50 beds), medium (51-250 beds), and large (over 250 beds).¹ Of the 289 surveyed hospitals, 53 hospitals were classified as small, 149 as medium-sized, and 87 as large.

Table 1. Summary of Hospitals Surveyed and Responses Received

Hospital Size	Hospitals Surveyed and Response Rate by Bed Size				
	Total Hospitals	Hospitals Surveyed	Responses Received	Response Rate	Percent of all Texas Hospitals Responding
Small (1-50)	265	53	45	84.9%	17%
Medium (51-250)	252	149	74	49.7%	29.4%
Large (251+)	87	87	52	59.8%	59.8%
Not Indicated	N/A	N/A	2	N/A	N/A
Total	604	289	173	59.9%	28.6%

As Table 1 indicates, the response rate for each category was relatively high. In total, 173 completed surveys were received, accounting for almost 60 percent of surveyed facilities and over 28 percent of all hospitals in Texas. (*Note: 161 of the 173 hospitals completed the entire survey; 12 of the respondents failed to respond to one or more question, not including question 7, which was optional.*) Small hospitals had the highest response rate, with 45 of 53 surveyed hospitals responding (85 percent). Medium-sized hospitals accounted for the highest share of responses (42 percent), with small and large hospitals responding at a similar rate (26 percent and 30 percent, respectively). Two hospitals did not indicate their bed size.

¹ The Texas Hospital Association assisted in defining these categories.

Regional Analysis

Survey responses were placed into one of eleven geographical regions: the Panhandle (Amarillo-Lubbock), Northwest Texas (Abilene-Wichita Falls), the Metroplex (Dallas-Fort Worth), Northeast Texas (Tyler), Southeast Texas (Beaumont), the Gulf Coast (Houston), Central Texas (Austin-Waco), South Central Texas (San Antonio), West Texas (Midland-Odessa), Far West Texas (El Paso), and the Rio Grande Valley (Corpus Christi-Brownsville). As Table 2 shows, the highest concentration of responses came from major urban areas: the Metroplex (25.4 percent), the Gulf Coast (18.5%), and Central Texas (12.1 percent). West Texas and Far West Texas were the least represented regions, accounting for 3.5 percent and 1.7 percent of total survey responses, respectively.

Table 2. Summary of Responses Received by Region

Region	Regional Analysis by Bed Size					Total	Percent of Total
	Small (1-50)	Medium (51-250)	Large (251+)	Not Indicated			
Panhandle	5	3	3	0		11	6.4%
Northwest Texas	3	3	2	0		8	4.6%
Metroplex	9	21	14	0		44	25.4%
Northeast Texas	6	4	2	1		13	7.5%
Southeast Texas	1	5	1	0		7	4.0%
Gulf Coast	3	16	13	0		32	18.5%
Central Texas	9	8	4	0		21	12.1%
South Central Texas	4	5	6	1		16	9.2%
West Texas	4	1	1	0		6	3.5%
Far West Texas	0	3	0	0		3	1.7%
Rio Grande Valley	1	5	6	0		12	6.9%
Total	45	74	52	2		173	100.0%
Percent of Total	26.0%	42.8%	30.1%	1.2%		100.0%	

Question 1. Does the hospital take any action to encourage the facility-based physicians to contract with the same health plans as the hospital? If yes, please describe.

An overwhelming majority of hospitals (91 percent) responded that they encourage physicians to contract with the same health plans as those that are included in the hospital's network. Of these 157 hospitals, 41 percent were medium-sized hospitals, 33 percent were large hospitals, and 25 percent were small hospitals. All 52 responding large hospitals answered affirmatively, though 71 percent did not specify what sort of encouraging action they take. Of those that reported specific actions, hospitals were most likely to either inform their facility-based physicians of the health plans with which the hospital contracts or require their physicians to contract with the same plans. These two

answers accounted for 9.8 percent and 8.1 percent, respectively, of the total responses to Question 1.

Seven hospitals indicated that they do not encourage their facility-based physicians to contract with the same health plans. Of these seven, five were medium-sized hospitals and two were small. The hospitals had an average of 75 beds.

Question 2. What information, if any, does the hospital routinely provide to health plans to inform them of the facility-based physicians with whom you have contracts or have granted medical staff privileges? How frequently is the information updated? How frequently is the information requested by or provided to health plans?

Over 90 percent of responding hospitals indicated that they update and provide physician rosters to health plans at least periodically and/or upon request. Medium-sized hospitals made up 40 percent of these 156 hospitals, with large and small hospitals totaling 33 percent and 26 percent, respectively.

Eleven hospitals (6.4%) either do not currently send updated information about their facility-based physicians to health plans or have no process in place to do so. All but one of these 11 were small or medium-sized hospitals, with an average of 74 beds.

Question 3. Do you have a process to monitor the number of your in-network patients who receive care from a facility-based provider who is out-of-network for one or more health plans? If yes, please describe the process. If you do not track the information, please explain whether you have attempted to do so in the past and the challenges of creating such a monitoring process.

Only 22 hospitals (13 percent) reported that they either attempt to track network adequacy situations or that these situations do not impact their patients. For half of these 22 hospitals, balance-billing situations are not an issue since they reported that their facility-based providers are in-network with all applicable carriers. Of the remaining 11 that do attempt to track this information, six hospitals did not specify what process they have in place while the other five use a complaint-driven process. Small hospitals were much more likely (24percent) to monitor the number of network adequacy situations than were large (10 percent) or medium-sized hospitals (8 percent).

A number of hospitals reported varying issues that hinder their ability to track this information. Just over a third of all hospitals (35 percent) do not know the network participation status of their facility-based providers, while another 10 percent do not have computer systems capable of tracking network status of providers. Other hospitals responded that they are not responsible for contract coordination and suggested patients and health plans should ensure they have access to in-network providers.

Question 4. Based on your experience negotiating contracts with both health plans and hospital-based physicians, what suggestions or recommendations do you have for addressing the problems associated with the balance-billing of out-of-network services by hospital-based physicians?

Question 4 generated a wide range of suggestions. As Table 3 indicates, two of the most common recommendations were that health plans should be required to contract with physicians (17 percent) and that physicians should be required to participate in hospital contracts (9 percent). Almost half of all hospitals (48 percent) did not provide a response.

Table 3. Summary of Responses to Question 4

Question 4 Responses	Number of Survey Responses by Bed Size					Total	Percent of Total
	Small (1-50)	Medium (51-250)	Large (251+)	Not Indicated			
Health plans should be responsible for contracting with facility-based physicians.	8	14	8	0		30	17.3%
Improve participation incentives and/or reimbursement rates for physicians.	7	7	8	0		22	12.7%
Require hospital-based physicians to participate in hospital contracts.	6	8	2	0		16	9.2%
Plans should be required to pay non-contracted providers at billed charges.	3	1	1	0		5	2.9%
Improved communication between all parties is needed.	2	1	2	0		5	2.9%
A greater emphasis on patient education and responsibility is needed.	1	2	0	0		3	1.7%
Combine in-network and out-of-network deductibles and require physicians to accept in-network deductible.	0	1	1	0		2	1.2%
Align physician compensation and performance incentives.	0	1	0	0		1	0.6%
Create a state-wide out-of-network fee schedule that is the maximum allowed fee for providers to charge.	0	0	0	1		1	0.6%
The state should create an acceptable definition of "fair & reasonable" and limit balance billing to these amounts.	1	0	1	0		2	1.2%
Hospitals should be required to notify patient if a physician is out-of-network.	1	0	0	0		1	0.6%
Require plans to indemnify patients for out-of-network balances and make it illegal for physicians to balance bill.	0	1	0	0		1	0.6%
Blank; n/a.	16	38	28	2		84	48.6%
Total	45	74	51	3		173	100.0%
Percent of Total	26.0%	42.8%	29.5%	1.7%		100.0%	

Question 5. One of the provisions of Senate Bill 1731 is a requirement that health plans clearly identify to their enrollees any facilities that include non-network facility-based physicians. This information must be identified in the health plan’s directories. Because health plans do not always know which facility-based physicians are under contract with or have been granted medical staff privileges by a hospital, we are attempting to coordinate the collection of data from health plans and hospitals. To ensure that the information we provide for your hospital is accurate, please list in the table below the names of the facility-based physician practice groups or physicians who are under contract with or have been granted medical staff privileges by the hospital. If there are multiple practice groups or physicians who have been granted privileges at the hospital for a particular type of practice, please list the practice groups or physicians who provide the greatest volume of services at the hospital. If you are reporting this information for more than one hospital, please duplicate this page and provide a separate chart for each facility.

Question 5 asked hospitals to provide a list of facility-based physician under contract or that had been granted privileges. The purpose of this question was to identify provider specialties where possible gaps in coverage could occur. Hospitals were most likely to report that they do not have any neonatologists either under contract or that had been granted privileges (Table 4). When combined with responses left blank, over 57 percent of hospitals did not list having a neonatologist. By comparison, only 4.6 percent of hospitals reported no contracted radiologist. Under 10 percent of hospitals reported having no pathologists, ER physicians, or anesthesiologists.

Table 4. Summary of Responses to Question 5

Hospital Size	Number of Surveyed Hospitals without Specified Physician / Group Under Contract or with Medical Staff Privileges									
	Anesthesiologists		ER Physicians		Neonatologists		Pathologists		Radiologists	
	None	Blank	None	Blank	None	Blank	None	Blank	None	Blank
Small (1-50)	11	8	5	5	26	13	6	6	4	5
Medium (51-250)	5	12	6	9	24	20	6	12	4	10
Large (251+)	0	2	2	2	8	6	0	3	0	2
Not Indicated	1	0	0	0	2	0	1	0	0	0
Totals	17	22	13	16	60	39	13	21	8	17
Percent of Total	9.8%	12.7%	7.5%	9.2%	34.7%	22.5%	7.5%	12.1%	4.6%	9.8%

Question 6. Does the hospital post on its website the names of facility-based physicians under contract or who have been granted medical staff privileges? If yes, how frequently is the information updated?

Over a third of hospitals (34 percent) post the names of facility-based physicians on its website, with this information updated either daily, periodically, or as needed. Additionally, four hospitals post the names of certain physicians (though not all), and

another seven facilities that do not currently post this information stated that they plan to do so. When analyzed by bed size, small hospitals (44 percent) were more likely to post physician names than either large (38 percent) or medium-sized hospitals (30 percent).

Question 7. If you have any additional information or data that you would like to share, please feel free to provide your comments below, or provide attachments.

As Table 5 shows, responses to Question 7 were varied. Less than 15 percent of respondents replied to the question, which was optional. Their responses are summarized in the following table.

Table 5. Summary of Responses to Question 7

Question 7 Responses	Number of Survey Responses by Bed Size					Total	Percent of Total
	Small (1-50)	Medium (51-250)	Large (251+)	Not Indicated			
Hospital works with patients so they will be more aware in advance of costs; better process needed.	2	3	0	0	5	2.9%	
Force facility-based physicians to contract and require health plans to be more open.	2	1	1	0	4	2.3%	
Hospital names and locations; provider list.	0	2	2	0	4	2.3%	
Facility-based physicians vary greatly in who they will contract with.	1	2	0	0	3	1.7%	
Providers in rural areas refuse to sign contracts; difficult to know what networks they are in.	2	0	0	0	2	1.2%	
Responsibility of insurance company; insurance companies to blame.	1	0	0	0	1	0.6%	
Situation changes too quickly for hospital to know what providers or insurers are doing.	1	0	0	0	1	0.6%	
Important for hospital to keep working relationship with providers' administrative staff.	0	0	1	0	1	0.6%	
Hospital has not been able to negotiate fair contracts with insurers.	0	1	0	0	1	0.6%	
Need standardization or clearinghouse for physician credentialing process.	0	1	0	0	1	0.6%	
Insurers "sell" network causing great confusion for hospital staff.	1	0	0	0	1	0.6%	
Facility participates in audio series on legislative issues, including SB1731.	0	0	1	0	1	0.6%	
No response; not applicable.	28	61	45	2	136	78.6%	
No; none; not at this time.	7	3	2	0	12	6.9%	
Total	45	74	52	2	173	100.0%	
Percent of Total	26.0%	42.8%	30.1%	1.2%	100.0%		

ADDENDUM

Because the committee was unable to reach consensus on some key issues, the three committee stakeholder groups (physicians, hospitals and health plans) agreed to include with this report separate position papers that provide additional information on each group's unique perspective. The following three documents provided by the Texas Association of Health Plans, the Texas Hospital Association and the Texas Medical Association are drafted solely by those entities and the stakeholders they represent and were not edited or reviewed by TDI or the other stakeholders that serve on the Committee. **As such, please note that these documents are not consensus papers and should not be considered as representing the opinion of the Texas Department of Insurance or the Advisory Committee as a whole.**



TEXAS HOSPITAL ASSOCIATION

Texas Hospital Association Addendum

Exclusive Contracts with Hospital-Based Physicians

Under federal and state law, hospitals are required to provide or arrange for the delivery of health care services to patients, including physician services, and frequently enter into contracts with physicians to assure that needed services are provided in a timely and efficient manner. Federal regulations relating to participation in the Medicare program specify how anesthesiology, emergency, laboratory, and radiology services are to be provided to patients and require that hospitals have an adequate number of qualified physicians available to provide these services. Further, hospitals are required to have these physician services readily available 24 hours a day and 7 days a week. The Texas Department of State Health Services has established similar regulatory requirements for hospitals licensed in the State of Texas.

In order to assure that physicians are available on a 24/7 basis to provide needed services to patients, hospitals frequently enter into contracts with various hospital-based physicians, including anesthesiologists, pathologists, and radiologists. In some instances these physician contracts will be entered into on an exclusive basis. From the hospitals' perspective exclusive contracts with these physicians provide a number of important administrative and operational advantages, including: assured physician coverage of the various clinical departments of the hospital; physician management and oversight of these clinical departments; and better management of the cost of these services.

As noted in the Advisory Committee Report, 91% of the hospitals that responded to the voluntary survey by the Texas Department of Insurance noted that they encouraged physicians on their medical staff to contract with the same health plans as the hospital, and a number of the hospitals through contracts with their hospital-based physicians required the physicians to contract with the same health plans. In addition, over 90% of the responding hospitals indicated that they update and provide physician rosters to health plans at least periodically or upon request by a health plan.

The Texas Hospital Association and the hospital representatives on the TDI Advisory Committee agree with the Report finding that the use of exclusive contracts by hospitals and health plans may impact patients' access to in-network providers; however, no evidence was presented to the committee to suggest that hospital exclusive contracts with hospital-based physicians was a significant contributing factor to the balance billing problem faced by some consumers. As noted in the Advisory Committee Report and discussed by physician representatives on the TDI Advisory Committee, the proposed reimbursement rates by the health plan and whether the health plan processes claims

promptly and accurately and has reasonable administrative requirements are the most important factors that influence whether physicians are willing to contract with a health plan. The physician representatives on the TDI Advisory Committee also noted that that gaps in participation in health plan networks by hospital-based physicians was often due to delays in the re-negotiation and renewal of the contracts with health plans. In contrast, hospital exclusive contracts with hospital-based physicians have a very limited impact on whether the physicians contract with health plans.

Recommendations to Address Network Adequacy and Balance Billing Problems

1. Chapter 1301, Insurance Code, relating to the operation of preferred provider benefit plans should be amended to establish more specific network adequacy standards for preferred provider plans, and these standards should address access to hospital and physician services (including primary care, hospital-based and other specialty services). Similar network adequacy standards should be established in any legislation to license and regulate preferred provider organizations.
2. Texas Department of Insurance oversight and enforcement of Chapter 1456, Insurance Code, relating to disclosure of provider status by health plans should be emphasized. This chapter, enacted by the Texas Legislature in 2007, was intended to improve health plan communication with enrollees concerning their provider networks and the potential for balance billing. However, based on the information presented to the Advisory Committee it appears that many health plans face difficulty in knowing whether a particular hospital-based physician in a participating provider in their network and where the physician has hospital privileges. Improving the accuracy of information provided to consumers on health plan networks and specifically, which hospital-based physicians are participating providers, would help reduce the potential for balance billing.

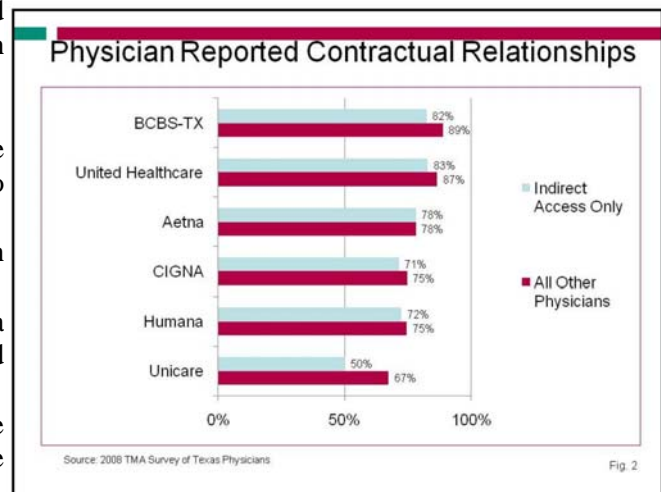
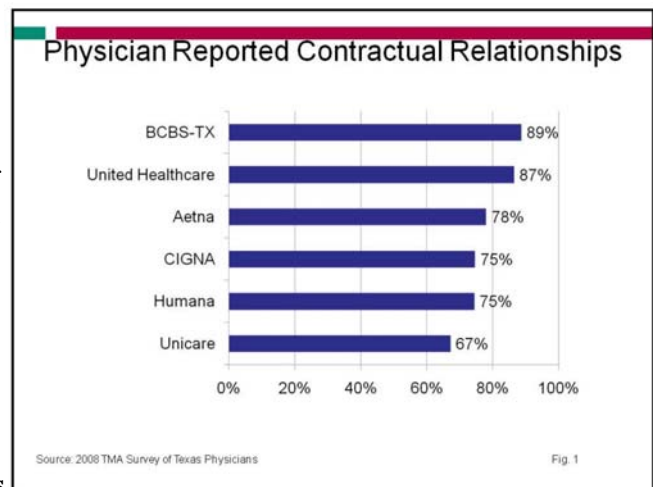
TMA Stakeholder Summary Document

Facility-based physicians do contract with health plans just like the general physician population. It is to the physicians’ benefit because they get paid more quickly and Texas’ prompt pay laws provide an incentive. Federal and state laws require physicians to stabilize anyone with an emergency medical condition regardless of the patient’s ability to pay. It even forbids physicians from inquiring about coverage until after the care is provided. In practice, even for non-emergent situations facility-based physicians treat first without regard to who provides payment. To ensure access to facility-based specialty services, hospitals and physicians enter into agreements. Senate Bill 1731 Network Adequacy Committee data illustrate that an overwhelming majority of medical services provided by facility-based specialists *on a statewide basis* were delivered in-network. Despite the appearance of network adequacy, the real issue for out-of-network services becomes — “Did the health plan fairly settle the claim?” Many patients don’t realize their financial responsibility is not based on the bill the health plan receives for out-of-network services. Instead, health plans use an “allowable amount” they determine to calculate the patient’s share of the medical loss. This calculation tends to cause the patient to pay more, while the health plan pays less. It is this “allowable” (and the tendency for it to be lower than the actual medical loss) that resulted in the Texas Department of Insurance (TDI) issuing an agreed to Disciplinary Order against Blue Cross/Blue Shield of Texas (TDI Order 08-0514) and spurred law enforcement in other states to investigate insurers.

Facility-Based Physician Network Participation

TMA conducted a statistically valid survey of physicians practicing in the state. That survey showed that physicians contract with all of the large plans in Texas and on average have 7 HMO contracts and 17 preferred provider benefit plan contracts (Fig. 1). *Facility-based physicians* on average have 7 HMO contracts and 11 preferred provider benefit plan contracts. **It also showed that indirect access physicians (or facility-based specialists) contract equally as often with most large health plans (except for BCBSTX and Unicare) as the non-facility based specialties** (Fig. 2). The voluntary claims data provided as an attachment to this report supports TMA survey results. As stated in the TDI report, ninety percent of the total facility-based physician claims/visits were delivered by in-network facility based physicians. The committee information coupled with TMA’s survey results:

1. Dispels for the Legislature assertions made by the health plans that physicians are unwilling to contract;
2. Shows there is no evidence of so-called physician “monopolies” affecting participation in network;
3. Refutes health plan allegations there is a pervasive and systematic attempt by facility-based physicians to avoid contracting with insurers; and
4. Dispels concerns that hospital/physician exclusive arrangements already in place contribute to the incidence of out-of-network claims.

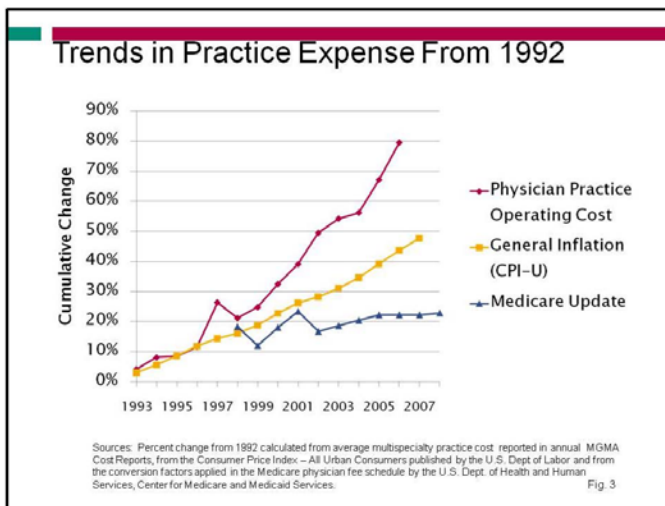


Physicians contract because they receive certain payment protections and guarantees under Texas' prompt payment provisions and will generally receive payments more quickly from health plans. Simply, the data shows an overwhelming majority of medical services provided by facility-based specialists *on a statewide basis* were delivered in-network (i.e. provided by a physician contracted with the health plan). Unfortunately, because the health plan data presented to the SB 1731 Workgroup was blinded and submitted in an aggregate fashion, neither the workgroup nor TMA could evaluate the status of the health plan networks in their local markets. This means it can't be determined where the patient may still be susceptible to receive out-of-network services.

A Tale of Apples versus Oranges (Or Medicare Payments versus Commercial Fees)

The Texas Association of Health Plans (TAHP) and individual insurers have been distributing insincere comparisons of physicians' charges expressed as a percentage of the federal government's Medicare fee schedule. This is TAHP's attempt to compare a primary care physician office-visit charge to a facility-based physician procedure based charge. Since, facility-based physicians do not provide "office visits" this comparison is disingenuous.

Legislators should be aware that federal law, (42 U.S.C. 1395w-4 (d)) requires that the Medicare physician fee schedule be budget neutral. This means that total Medicare spending for physician services must be the same under a new payment update as it was under the previous update. The commercial market for physician services is *not* reflected in the Medicare schedules. The use of percentages to demonstrate unfair physician charges is invalid because the basis for comparison is not the same across specialties under Medicare. The basis of the TAHP percentages has no real connection to practice costs or the marketplace environment and is like comparing apples to oranges when evaluating physician charges utilizing the budget neutral government fee schedule (Fig.3). Figure 3 clearly illustrates the Medicare fee schedule:



1. Has not accounted for general inflation;
2. Is set artificially low to meet federal budget needs; and
3. Does not keep pace with operating costs.

Exclusive Arrangements

Facility-based physician groups who provide inpatient services also want to provide outpatient services. Physicians prefer to have contracts with health plans that encompass both inpatient and outpatient services. For instance, a pathologist group could provide both inpatient and outpatient services if given such a contract offer. This arrangement provides greater access to in-network physicians and less out-of-pocket costs for patients, since the same physician group is providing those services regardless of where the patient may receive them. However, some health plans will not contract with physicians for outpatient services that are performed outside the facility (e.g., at ambulatory surgical centers or office-ordered labs). Instead, health plans will exclusively contract with national companies for the outpatient services. For example, in 2006 United Healthgroup and North Carolina-based LabCorp entered into a 10-year agreement in which LabCorp became United Healthcare's preferred national pathology laboratory. The contract was valued in excess of \$3 billion.

State and federal laws place upon each and every physician an obligation to stabilize, *without inquiry into insurance coverage or ability to pay*, each patient who comes to the emergency room with an emergency medical condition. *All who need care receive it*. The basic effect of these laws is that, unlike office-based practices, facility-based physicians have little or no ability to control their "payor mix." In actual practice, even

in non-emergency situations, facility-based physicians still treat first and address payment later. As pointed out previously, Medicare does not and has not, kept pace with the cost of a physician’s medical practice. The same can be said of other government payors. Thus, when a health plan approaches a facility-based physician to negotiate, this marketplace reality must be taken into account when a facility-based physician considers the offer. Indeed, the reason for many hospital-physician agreements is to *guarantee access to critical specialties* like emergency medicine, pathology, anesthesiology, and radiology. Where the physician can come to an agreement with a health plan, it means the chances of those insured patients encountering an out-of-network facility-based physician of that specialty dramatically decreases.

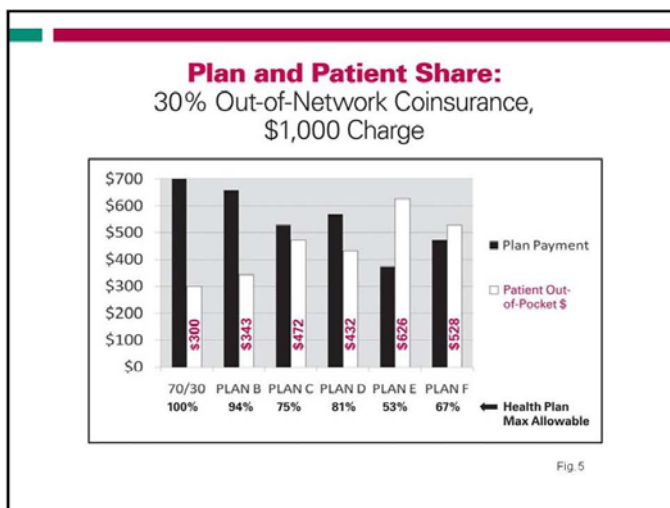
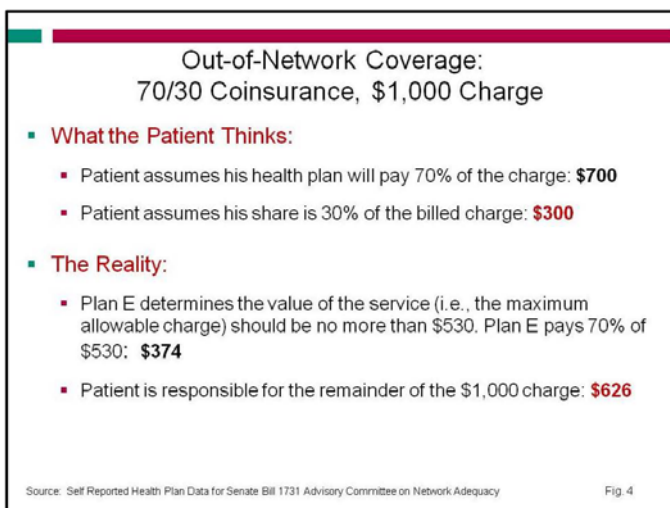
It is essential for the Legislature to know health plans will attempt to “reverse cherry-pick” in the marketplace by ensuring that facility-based physicians located in your communities are refused contracts for the full spectrum of their services. When health plans fail to offer physicians contracts that allow them to be in-network for inpatient and outpatient services, the health plan single-handedly increases the likelihood that patients will have greater out-of-pocket financial costs. This practice will impede convenient access to certain on-site outpatient services as well.

The Impact of the Health Plan’s Usual and Customary Determination/Maximum Allowable on Patient Out-of-Pocket Costs and Balance Billing

When a patient purchases health insurance coverage with a 70/30 coinsurance payment for an out-of-network service, he or she expects to pay 30 percent of the amount charged – the actual medical loss. When a physician bills the health plan \$1,000 for an out-of-network service, the patient assumes the health plan will pay \$700, and he or she will pay \$300. However, this is not the case (Fig. 4). Health plans pay their percentage of the patient’s claim based on what they determine is the maximum “allowable amount” for that medical service. A major Texas health plan defines the “allowable amount” as the “maximum amount determined by [PLAN] to be eligible for consideration of payment for a particular service, supply or procedure.”

As TDI’s table in the “Reimbursement Calculations” section of 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.

To illustrate this point, let’s use the maximum allowable amounts reported to the workgroup by the five health plans for out-of-network services. In this scenario, we assume that all five health



plans cover 70 percent of the out-of-network allowable amount. The patient covered under Plan E is expecting to pay 30 percent of the charge, or \$300; instead, the patient pays 63 percent of the charge, or \$626, for an out-of-network charge of \$1,000 (Fig. 4). Plan E pays only \$374 on the patient's claim because that is 70 percent of its allowable amount. At the same time, a patient covered under Plan B pays only \$343 for the same service because Plan B paid \$657, based on its average percentage maximum allowable amount of 94 percent (Fig. 5).

The maximum allowable amount reported by each of the five health plans varied dramatically. Plan E reported that its maximum allowable amount for out-of-network services, on average, is 53 percent of actual billed charges. No other health plan reported limiting its out-of-network maximum allowable to that degree.

State Enforcement Activities

The importance of the Insurance Code placing fiduciary duties upon insurers, such as mandating that insurers effect, in good faith, a prompt, fair, and equitable settlement of a claim submitted on the benefit of their insured was recently revealed when TDI entered into an Agreed Order with BCBSTX. TDI alleged that, "BCBSTX's reimbursement rates are unreasonably low in light of representations made by the company in its advertising and its policies and that the reimbursement rates are so low as to violate Texas insurance laws and regulations." BCBSTX denied the allegations, but nonetheless settled for \$3.9 million and agreed to modify its method of determining the "allowable" for certain facilities.

The New York Attorney General is investigating similar activities. He contends that Ingenix (a company that has compiled a claims database for hire) operates "a defective and manipulated database" and that two United HealthGroup subsidiaries relied on those data to "dramatically under-reimburse" members for out-of-network medical expenses. The Attorney General characterized it as "a scheme to defraud consumers" at a February press conference which health plans likely dispute as untrue. New York has issued 16 subpoenas to other health plans — including Aetna, Inc., CIGNA Corp., Humana Inc. and WellPoint, Inc. subsidiary Empire Blue Cross Blue Shield — to determine how they calculate UCR or "allowable" rates.

Conclusion

All of this information leads to a surprising discovery: A patient's out-of-pocket costs for out-of-network services are impacted dramatically by:

- The adequacy of the health plan's network; *and*
- The amount the health plan pays toward the patient's claim based on the health plan's determination of its maximum allowable amount for the out-of-network service.

In addition, due to the great variations in what each plan paid out-of-network, it is very evident that how health plans determine a "maximum allowable" for out-of-network services is not consistent, not well understood nor transparent to the patient.

Recommendations

1. Call for more health insurance transparency. There must be a better understanding of how preferred provider benefit plans are designed and administered.
2. For the protection of insured Texans, the Legislature should seek disclosure in how preferred provider benefit plans determine "maximum allowables" and the impact of those determinations on out-of-pocket costs.
3. Authorize the Texas Department of Insurance to review data mining companies that supply price information to insurers, along with authority to regulate how preferred provider benefit plans utilize the services of data mining companies, such as determining the "maximum allowable," as a consumer protection.
4. Examine the integrity of each health plan's network in local markets to determine where preferred provider benefit plans are not delivering the network promised to consumers.
5. Require a standard insurance label to be placed on all preferred provider benefit plan offers and advertisements. This label will permit consumers to make side-by-side comparisons through a standardized layout containing important information, such as the percentage of expenses paid by the Plan In-Network, the percentage of expenses paid by the Plan Out-of-Network, and annual out-of-pocket expenses.



1001 Congress, Suite 300 Austin, Texas 78701
Phone 512-476-2091 Fax 512-476-2870
www.tahp.org

December 15, 2008

Ms. Dianne Longley
Director of Research & Analysis, Life/Health Division
Texas Department of Insurance

Dear Ms. Longley,

Please accept the following comments on behalf of the Texas Association of Health Plans (TAHP) as an addendum to the final report of the Health Network Adequacy Advisory Committee (HNA) established by Senate Bill 1731. TAHP represents nearly every health plan providing coverage in Texas and its member plans cover a majority of the insured in Texas.

Background

The HNA was included in Senate Bill 1731 to study the various elements contributing to the issue of balance billing, an issue which has received much attention in Texas and throughout the country in recent years. Balance billing occurs when enrollees of a health plan receive care from non-contracted providers who bill patients for amounts not covered by their health plan. Balance billing is particularly troubling when a health plan enrollee seeks care at an in-network facility and ends up being treated by a non-contracting provider. Most patients assume that such providers work for the hospital or that providers at an in-network facility must also be considered to be in-network. Enrollees are understandably upset when they receive bills from providers for services they believed to be covered.

Organized medicine has charged that the primary cause of balance billing is the inadequacy of health plan networks. As noted in the report, a small percentage of claims are actually delivered by non-contracted providers. Further, data submitted by organized medicine suggests that an average of 75% of physicians in the state are contracted with health plans, a number that contradicts claims that plans have inadequate networks.

Health plans believe that balance billing is primarily a result of facility-based providers, radiologists, anesthesiologists, pathologists, and emergency room physicians (often referred to collectively as "RAPs") exercising their effective monopoly in order to charge excessive rates. In order to comply with federal and state regulations, hospitals must have sufficient providers staffing the hospital. In order to ensure they have such staffing, hospitals often grant physician groups such as RAPs "exclusive privileges." Exclusive privileges provide that only physicians from a certain practice group will be allowed to provide services within that hospital.

Network Adequacy

The HNA report provides a good description of the requirements that health plans are subject to in order to ensure access to services for their enrollees which include provisions that providers must be accessible within a certain number of miles and that health plans must provide out-of-network benefits at an in-network level if providers are not available within the network. The HNA looked at numerous pieces of data and, to date, nothing has been submitted to the Committee that suggests that health plan networks are inadequate. To the contrary, the HNA has received data showing that out-of-network claims are rare (10%), that complaints related to access or availability of providers are virtually non-existent, and that the vast majority of providers are under contract with major health plans. Put simply, network adequacy of health plans is a non-issue.

Exclusive Privileges

The granting of exclusive privileges to the provider group has a significant impact on the ability of

health plans to contract with such provider groups. Because these provider groups have been guaranteed exclusive rights to treat patients entering the hospital, they are often unwilling to contract with health plans at reasonable rates. Included as part of this addendum is information collected by health plans that details the effect exclusive privileges has on the rates demanded by facility-based providers. In the attached chart, the data collected compares the charges of office-based providers (primary care physicians and other office-based specialists) to the rates charged by facility-based providers. Whereas office-based providers who do not have exclusive privileges generally charge rates that are between 125-215% of the rate paid by Medicare, facility-based providers charge between 386-2300% of the rate paid by Medicare for the most commonly billed services. (Note: Medicare is used as a baseline as it is the largest payer of health care services in the country and its fee schedule is used by almost all other payers to determine reimbursement.) Such wide variation in charges is difficult to explain away and can create situations where consumers face large and unexpected costs.

Organized medicine representatives have noted that health plans, too, engage in selective contracting. There is, however, a crucial difference as health plan efforts to contract must be consistent with providing sufficient access to health plan enrollees as required by law. Health plans develop networks to maintain quality and contain costs, but access to providers is required by law. No similar requirement exists for providers. When hospitals and physicians enter into exclusive arrangements, there is no requirement that physicians must participate in the networks of health plans that contract with the hospital.

Provider Charges

Provider charges are essentially unregulated and uncapped. As mentioned above, physician charges for the same service will vary significantly. Although, in theory, the Texas Medical Board (TMB) has the authority to discipline providers for submitting bills that are "unreasonable", data from the TMB suggests that the Board rarely, if ever, takes action against providers for unreasonable charges. TAHP requested from TMB data on the number of complaints against providers involving billing practices and the number of actions taken by the Board. The TMB has stated that there were a total of 821 complaints filed with the TMB since June 3, 2003, with an allegation code of "persistently or flagrantly overcharging or over treating patients." Board records indicate that no action was taken in these cases as a result of overcharging or overtreating patients.

Provider charges play a significant role in determining what a patient will pay for out-of-network services. Health plans offer out-of-network benefits to ensure that patients have broad access to care. However, while the out-of-network benefit is intended to promote access and choice, it is not intended to provide a blank check to providers. As the attached information shows, facility-based providers utilize the position granted to them by the hospital to charge rates far in excess of those charged by their office-based counterparts. The charges, **on average**, for an emergency room physician are 400% of what Medicare pays for the same service, but many charge substantially higher rates.

A recent development has been the proliferation of physician-owned facilities, particularly in Texas. Some of these facilities utilize a business model that is designed to manipulate the out-of-network benefit. Under this model, physicians will refer patients to facilities in which they have an ownership interest and promise to waive cost sharing obligations for the patient. The charge for the service is set far above the market rate for services, often 500-1000% the rate charged by other providers in the area. Under this model, the provider can treat a patient with a 60/40 benefit for out-of-network services (under which the plan would pay 60% and the enrollee 40%), waive the patient's 40% coinsurance obligation as an inducement (in violation of the law), and collect 60% of their charge from the health plan. If the health plan caps reimbursement at a certain level, the patient may face a significant bill.

Regulatory Oversight

The HNA report mentions that TDI lacks the authority to compel data from either hospitals or health plans as their oversight authority is limited to health plans. Data provided by hospitals and physicians is completely voluntary. Not only does TDI lack authority, but the agencies that license hospitals and physicians, the Department of State Health Services (DSHS) and the TMB

respectively, also lack the authority to collect such data, let alone to address abuses. TAHP believes this is a serious regulatory gap as regulators and policymakers lack the data needed to make recommendations to the Legislature. The basic question of how many instances of balance billing occurred in Texas cannot be answered as the entity engaging in balance billing, the physician, has no obligation to collect or provide such information. Consumers are negatively impacted by this lack of oversight. For example, complaints related to hospital billing practices, which have been featured in the pages of major national newspapers, are not even tracked in Texas. Rather, hospitals are allowed to establish their own complaint process. TAHP believes that the Legislature should ensure that TDI and the appropriate licensing agencies have the authority necessary to collect information from physicians and hospitals as well as explicit authority to take action on billing complaints.

Solutions

TAHP recognizes that balance billing is a serious problem that can adversely impact consumers and believes that patients should not be balance billed by providers when they seek services at an in-network facility. TAHP has discussed numerous policy options that would remove consumers from the middle and provide a fair resolution to this issue, including:

- Requiring hospitals that grant exclusive privileges to provider groups to also require that those groups contract with the same health plans as the hospital
- Amend the state's assignment of benefit law to provide that a physician who accepts payment from a health plan foregoes the right to balance bill
- Create an independent review process to settle disputes between providers and health plans
- Amend the state's corporate practice of medicine statute to allow hospital to directly hire physicians

TAHP believes all of the options listed above would benefit the consumer by limiting inappropriate balance billing without unfairly punishing any of the parties involved.


Conclusion

The Health Network Adequacy Advisory Committee was established to study health plan network adequacy and other variables impacting the prevalence of balance billing. Based on the data submitted by health plans and providers alike, there is abundant evidence that network adequacy among health plans is strong and there was no data offered to the committee to suggest otherwise. The argument that inadequate health plans networks are the cause of balance billing has now been studied and found to be wanting.

While the work of the HNA did not conclude with any unanimous recommendations, health plans have provided significant new data that will help to inform the debate moving forward. TAHP's primary goal is to ensure that enrollees seeking services at in-network facilities are protected from balance billing and to ensure that consumers have access to consumer protections when facing exorbitant charges from providers. TAHP has offered a number of policy options to address balance billing and will continue to work with policymakers to address the issue.

Again, thank you for the opportunity to provide comments and for your hard work in balancing the various viewpoints offered by consumers, health plans, hospitals, and providers.

Sincerely,



Jared Wolfe
Executive Director

Examples of Billed Charges for PCPs vs. Facility-based Physicians

Physician Charges Compared to Medicare

Office Visit by CPT Code	PCP	Specialist
	Weighted Average as a % of Medicare	Weighted Average as a % of Medicare
99211	216%	213%
99212	184%	161%
99213	146%	136%
99214	135%	130%
99215	125%	128%

Hospital-based Pathologists

Procedure		Hospital-based Pathologist	Hospital-based Pathologist
Doctor Service by HCPCS Code (w/ Modifier 26)	Description	Weighted Average as a % of Medicare	Std. Dev +1 of weighted avg. as a % of Medicare
88300	Surgical Pathology, Gross	2003%	2367%
88302	Surgical Pathology, Complete	1893%	2297%
88305	Tissue Exam By Pathologist	669%	788%
88307	Surg Pathology, With Dissect	481%	566%
88309	Surg Pathology, W Or W/O Dis	390%	424%

Hospital-based Emergency Physicians

Procedure	ER Physician	ER Physician
Doctor Service by CPT Code	Weighted Average as a % of Medicare	Std. Dev +1 of weighted avg. as a % of Medicare
99281	406%	511%
99282	416%	536%
99283	457%	570%
99284	390%	487%
99285	386%	478%

Hospital-based Radiologists

Procedure		Hospital-based Radiologists	Hospital-based Radiologists
Doctor Service by HCPCS Code (w/ Modifier 26)	Description	Weighted Average as a % of Medicare	Std. Dev +1 of weighted avg. as a % of Medicare
70450	Cat Scan Of Head Or Brain	443%	546%
71010	X-Ray Exam Chest Single View	407%	488%
71020	Xray Exam Chest Two Views	423%	493%
72193	Contrast Cat Scan Of Pelvis	401%	474%
74160	Contrast Cat Scan Of Abdomen	408%	483%

OTHER STATES' ACTIVITIES

Several states have enacted either statutory or regulatory requirements related to network adequacy and/or balance billing. The approaches vary significantly. Although the Committee briefly discussed how other states have dealt with this issue, there is wide disagreement among the members as to the effectiveness or appropriateness of other states' decisions.

The Committee recognizes that the Legislature is interested in other states' activities and, therefore, agreed to include a summary of information even though many members do not support the approaches used in other states. The inclusion of this information should *not* be interpreted as a recommendation by the Committee that the Legislature should consider these options as a solution for Texas. The information attached is limited to a summary of statutory and regulatory requirements enacted in these states. The summary does not include information on court decisions or administrative actions that may have been taken with regard to a particular insurer within a state. The summary is attached.

THIS PAGE INTENTIONALLY LEFT BLANK

State	Code/Rule/Opinion	Entity Regulated
Alabama	<ul style="list-style-type: none"> • Contractual hold harmless provisionsⁱ • No additional financial liability to enrollee on referral to nonparticipating specialistⁱⁱ 	HMOs
Alaska	<ul style="list-style-type: none"> • Restrictions concerning determination of health service paymentsⁱⁱⁱ 	Persons that provide coverage for health care services or supplies on an expense incurred basis
Arizona	<ul style="list-style-type: none"> • Contractual hold harmless provision^{iv} • Enrollee may seek health care services from a contracting or noncontracting provider or hospital and accept financial responsibility for those services^v 	HMOs
Arkansas	<ul style="list-style-type: none"> • Contractual hold harmless provision^{vi} 	HMOs
	<ul style="list-style-type: none"> • Re: point-of-service option for dental benefits, limitation on ability of out-of-network dentist to balance bill for charges not otherwise reimbursed based on failure of provider to disclose a reasonable range of total charges after request by the covered person in advance of treatment^{vii} 	insurance company, health maintenance organization or hospital and medical service corporation
	<ul style="list-style-type: none"> • Provider contracts must contain provision holding covered member harmless for medical service determined not to be medically necessary^{viii} • Medically necessary services not covered by policy are insured's responsibility^{ix} • Limitation on differential payable for medically necessary, covered medical services from a non-preferred provider^x 	insurer, health maintenance organization, hospital, or medical service corporation offering a minimum basic benefit policy pursuant to 23 Ark. Code Chapter 98I
California	<ul style="list-style-type: none"> • contractual hold harmless provisions^{xi} • defines factors which must be considered in determining payment of the reasonable and customary value for health care services^{xii} • health care service plan responsible for payment of emergency and necessary post-stabilization medical services^{xiii} • (approved pending regulation)- defines unfair billing practices by non-contracted providers of emergency health care services 	health care service plans

State	Code/Rule/Opinion	Entity Regulated
	such that providers must bill only the health care service plan ^{xiv} -exception for copayments, deductibles, coinsurance	
Colorado	<ul style="list-style-type: none"> • requires referral if carrier has no participating providers of necessary expertise with payment at no greater cost to covered person than if benefit were obtained from participating providers^{xv} • non-HMO managed care plan may require further reasonable travel to participating provider in some circumstances^{xvi} • for intentional use of nonparticipating provider, carrier must pay lesser of: <ul style="list-style-type: none"> -bill charges; -a negotiated rate; or -greater of carrier's avg. in-network rate or the usual, customary and reasonable rate (and balance billing allowed)^{xvii} • transparency/ disclosure requirements regarding network adequacy^{xviii} • Covered services at network facility require coverage for services provided by non-network providers such that covered person suffers no greater cost than if services were obtained from in-network provider^{xix} • Hold harmless provisions^{xx} 	HMOs and carriers offering managed care plans
Connecticut	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{xxi} 	Health care centers, HMOs, managed care organizations
Delaware	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{xxii} 	Managed care organizations-hold harmless provisions
	<ul style="list-style-type: none"> • Referral for medically necessary services where provider not reasonably available from network provider^{xxiii} <ul style="list-style-type: none"> -must be reimbursed at previously agreed-upon or negotiated rate -balance billing prohibited • Emergency care services performed by non-network providers^{xxiv} <ul style="list-style-type: none"> -must reimburse at agreed-upon or negotiated rate regardless of 	Policy or contract of health insurance, including health service corporation contract/policy, which designates network physicians or providers or preferred physicians or providers

State	Code/Rule/Opinion	Entity Regulated
	<p>existence of contract with insurer - if parties cannot reach agreement on rate, provider is entitled to rates and charges allowed by Insurance Commissioner following arbitration</p>	
Florida	<ul style="list-style-type: none"> • balance billing prohibitions regardless of existence of contract, as outlined in statute^{xxv} • non-contracted provider of emergency medical services reimbursed lesser of: <ul style="list-style-type: none"> -provider's charges -usual and customary -mutually agreed charge^{xxvi} • billing limited to discounted rates under discount medical plan^{xxvii} 	<p>HMOs</p> <p>Discount medical organizations</p>
Georgia	<ul style="list-style-type: none"> • contractual hold harmless provisions^{xxviii} • coinsurance percentage differentials applicable to preferred and non-preferred provider services may not exceed 30%^{xxix} • coinsurance percentage for benefit levels for preferred and non-preferred providers may not exceed 40%^{xxx} • full disclosure of limitations, differentials, penalties, incentives or other arrangements by which insurer provides for gatekeeper^{xxxi} • contractual hold harmless provisions^{xxxii} • any coinsurance in consumer choice option shall not exceed 10% difference between in and out of network • maximum differential for out-of-pocket expenditures of consumer choice plan may not exceed 20% as compared to in-network^{xxxiii} 	<p>Preferred provider insurance policies or certificates</p> <p>Health care corporations</p> <p>Consumer choice plans</p>
Hawaii	<ul style="list-style-type: none"> • contractual hold harmless provisions^{xxxiv} 	HMOs

State	Code/Rule/Opinion	Entity Regulated
Idaho	<ul style="list-style-type: none"> • providers who accept referral from managed care organization are prohibited from balance billing^{xxxv} • managed care organization may not contract with provider under provisions requiring member to guarantee payment for services other than copayments, deductibles, and coinsurance^{xxxvi} • providers shall not require member payments for covered services other than copayments, deductibles, and coinsurance after written agreement to accept the managed care organization's reimbursement rate^{xxxvii} 	Managed care organizations
Illinois	<ul style="list-style-type: none"> • contractual hold harmless provisions^{xxxviii} • disclosure requirements for point-of-service contracts and evidences of coverage^{xxxix} • on reasonable demand, HMO must pay charges for emergency transportation by ambulance^{xi} -provider agrees not to balance bill enrollee by accepting payment 	HMOs
	<ul style="list-style-type: none"> • health care plan coverage for emergency services performed by plan or non-plan provider shall be at the same benefit level as if the services or treatment had been rendered by the health care plan physician licensed to practice medicine in all its branches or health care provider^{xii} 	plan that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution.
Indiana	<ul style="list-style-type: none"> • contractual hold harmless provisions^{xlii} • referral to out of network provider required if medically necessary services are not available in-network -HMO shall pay out-of-network provider the lesser of usual, customary and reasonable charge or amount agreed to between HMO and out-of-network provider -balance billing prohibited^{xliii} • HMO shall cover expenses for emergency services at a rate equal to the lesser of the following: 	HMOs

State	Code/Rule/Opinion	Entity Regulated
	<ul style="list-style-type: none"> -usual, customary, and reasonable charge; or -amount agreed to between the health maintenance organization and the out of network provider -balance billing prohibited^{xliv} 	
Iowa	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{xlv} • Reimbursement of emergency services may not be denied solely on the basis of performance by non-contracted provider^{xlvi} 	HMOs
	<ul style="list-style-type: none"> • Emergency services reimbursed as though covered person had been treated by a preferred provider^{xlvii} • Clear disclosure of differentials in benefit levels for preferred vs. non-preferred provider services^{xlviii} • Differences in benefit levels payable to preferred providers compared to non-preferred providers shall not unfairly deny payment and can be no greater than necessary to incentivize use of preferred providers^{xlix} 	Health benefit plan providing incentives for use of preferred providers
Kansas	<ul style="list-style-type: none"> • HMO may not contract with provider under provisions requiring member to guarantee payment for services other than copayments, deductibles, and coinsuranceⁱ 	HMOs
	<ul style="list-style-type: none"> • Network shall not be determined to be insufficient for failure to contract with any provider unwilling to contract under the same terms, conditions, reimbursement levels as insurer offers to similarly situated health care providersⁱⁱ 	Health plans-- means any hospital or medical expense policy, health, hospital or medical service corporation contract, a plan provided by a municipal group-funded pool, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans.
Kentucky	<ul style="list-style-type: none"> • Contractual hold harmless provisionsⁱⁱⁱ 	Managed care plans- " Managed care " means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of

State	Code/Rule/Opinion	Entity Regulated
		appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan
Louisiana	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{liii} • Non-contracting provider may pursue collection from HMO for emergency services provided the provider has no direct knowledge/information that patient is HMO enrollee^{liv} <ul style="list-style-type: none"> - provider may collect amount paid to participating providers from HMO - provider may collect balance from patient • Nonparticipating anesthesiologist, pathologist, radiologist who provides services at participating facility may pursue collection from HMO provided physician has no direct knowledge/information that patient is HMO enrollee^{lv} <ul style="list-style-type: none"> - provider may collect amount paid to participating providers from HMO - provider may collect balance from patient 	HMOs
	<ul style="list-style-type: none"> • Balance billing prohibition for contracted providers for amounts in excess of contracted rate^{lvi} • Issuer obligated to pay contracted provider the contracted reimbursement rate, and to extent issuer does not pay provider amount equal to issuer liability, contracted provider may collect difference from insured or enrollee^{lvii} 	Health insurance issuers contracting with a network of providers
Maine	<ul style="list-style-type: none"> • HMO contractual hold harmless provisions^{lviii} 	HMOs
	<ul style="list-style-type: none"> • Disclosures of balance billing possibility^{lix} 	All policies, contracts and certificates issued by a carrier under which the insured or enrollee may be

State	Code/Rule/Opinion	Entity Regulated
		subject to balance billing when charges exceed a maximum considered usual, customary and reasonable
Maryland	<ul style="list-style-type: none"> Statutory hold harmless provisions for in-network services and covered services performed by out-of-network providers^{lx} Statutory payment and transparency guidelines for out-of-network provider payments^{lxi} 	HMOs
Massachusetts	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxii} 	HMOs
Michigan	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxiii} For emergency or authorized service, HMO pays reasonable expenses or fees^{lxiv} 	HMOs
Minnesota	<ul style="list-style-type: none"> Hold harmless provisions^{lxv} 	HMOs
Mississippi	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxvi} 	HMOs
Missouri	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxvii} 	HMOs
Montana	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxviii} Carrier shall pay for emergency services in service area from non-network provider^{lxix} 	Managed care plans (a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment).
Nebraska	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxx} Health carriers providing benefits for emergency services responsible for charges for medically necessary emergency services, including out-of network services^{lxxi} 	Managed care plans (a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier)
Nevada	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxxii} 	HMOs
	<ul style="list-style-type: none"> Managed care organization may not refuse to pay contracted providers in certain low population areas if covered emergency 	Managed care organizations, where "managed care " means a system for delivering health care services that encourages the efficient use of

State	Code/Rule/Opinion	Entity Regulated
	services are provided at a contracted facility ^{lxxiii}	health care services by using employed or independently contracted providers of health care and by using various techniques which may include, without limitation: 1. Managing the health care services of an insured who has a serious, complicated, protracted or other health-related condition that requires the use of numerous providers of health care or other costly services; 2. Providing utilization review; 3. Offering financial incentives for the effective use of health care services; or 4. Any combination of those techniques.
New Hampshire	<ul style="list-style-type: none"> <li data-bbox="464 638 982 667">Contractual hold harmless provisions^{lxxiv} 	Managed care plans (health benefit plans that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier)
New Jersey	<ul style="list-style-type: none"> <li data-bbox="464 821 982 850">Contractual hold harmless provisions^{lxxv} <li data-bbox="464 911 1251 967">Emergency care cost sharing for enrollees the same for out-of-network as for in-network^{lxxvi} 	HMOs Carriers utilizing selective contracting arrangements (arrangements for the payment of predetermined fees or reimbursement levels for covered services by the carrier to network providers, HMOs, certified organized delivery systems (ODSs), licensed ODSs or, with respect to prescription drug coverage only, to PPOs. A SCA includes an arrangement between a carrier and an HMO under which the HMO makes its provider network available to the carrier)
New Mexico	<ul style="list-style-type: none"> <li data-bbox="464 1211 982 1240">Contractual hold harmless provisions^{lxxvii} <li data-bbox="464 1243 1272 1365">Managed health care plan must allow referral out-of-network for medically necessary services not reasonably available through the network^{lxxviii} -fully reimburse non-participating physician or provider at “usual 	Managed health care plans (health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers

State	Code/Rule/Opinion	Entity Regulated
	<p>and customary” or agreed upon rate -division may rely upon accepted insurance industry standards to determine whether rate is usual and customary</p>	<p>managed, owned, under contract with or employed by the health care insurer or provider service network. "Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies.)</p>
New York	<ul style="list-style-type: none"> • Specialty care^{lxxix} <ul style="list-style-type: none"> -referral required if no appropriate in-network provider is available -no cost to insured beyond what insured would otherwise pay for in-network services 	<p>Managed care products (a contract which requires that all medical or other health care services covered under the contract, other than emergency care services, be provided by, or pursuant to a referral from, a designated health care provider chosen by the insured (i.e. a primary care gatekeeper), and that services provided pursuant to such a referral be rendered by a health care provider participating in the insurer's managed care provider network. In addition, in the case of (i) an individual health insurance contract, or (ii) a group health insurance contract covering no more than three hundred lives, imposing a coinsurance obligation of more than twenty-five percent upon services received outside of the insurer's provider network, and which has been sold to five or more groups, a managed care product shall also mean a contract which requires that all medical or other health care services covered under the contract, other than emergency care services, be provided by, or pursuant to a referral from, a designated health care provider chosen by the insured (i.e. a primary care gatekeeper), and that services provided pursuant to such a referral be rendered by a health care provider participating in the insurer's managed care provider network, in</p>

State	Code/Rule/Opinion	Entity Regulated
		order for the insured to be entitled to the maximum reimbursement under the contract
	<ul style="list-style-type: none"> End of life care^{lxxx} <ul style="list-style-type: none"> - absent agreed rates, insurer shall pay for acute care at acute care rate under Medicare rate - payment by insurer constitutes payment in full and balance billing is prohibited 	insurers and HMOs that provide coverage for acute care services
	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxxxix} 	HMOs
	<ul style="list-style-type: none"> Emergency ambulance services^{lxxxii} <ul style="list-style-type: none"> -payment by insurer is payment in full/balance billing prohibited -reimbursement is at negotiated rate or, absent agreed upon rates, usual and customary charge, which shall not be excessive or unreasonable 	insurers, hospital service corporations
North Carolina	<ul style="list-style-type: none"> Contractual hold harmless provisions, unless the HMO maintains a special deposit from which unpaid/uncovered claims are paid^{lxxxiii} 	HMOs
	<ul style="list-style-type: none"> Deductibles and copayments must be based on discounted rate for service^{lxxxiv} 	Health benefit plans
North Dakota	<ul style="list-style-type: none"> Contractual hold harmless provisions^{lxxxv} 	HMOs
Ohio	<ul style="list-style-type: none"> If provider network insufficient, coverage of benefits at no greater cost to the covered person than if enrollee had obtained the service from a contracted provider or health care facility^{lxxxvi} hold harmless provisions^{lxxxvii} Co-payments and deductibles must be reasonable, annual maximum cap^{lxxxviii} 	Health insuring corporations
	<ul style="list-style-type: none"> No balance billing^{lxxxix} 	Individual sickness and accident policies
Oklahoma	<ul style="list-style-type: none"> Contractual hold harmless provisions^{xc} 	HMOs
Oregon	<ul style="list-style-type: none"> Contractual hold harmless provisions^{xcii} 	Health Care Service Contractors, multiple employer welfare arrangements

State	Code/Rule/Opinion	Entity Regulated
Pennsylvania	<ul style="list-style-type: none"> Contractual hold harmless provisions^{xcii} 	HMOs
	<ul style="list-style-type: none"> Emergency health care services^{xciii} -no greater out of pocket for insured than had services been furnished by preferred provider 	Preferred provider arrangements
Rhode Island	<ul style="list-style-type: none"> Statutory hold harmless provisions; applies to any provider for charges for covered services provided or made available to enrolled participants by a licensed health maintenance organization^{xciv} 	HMOs
South Carolina	<ul style="list-style-type: none"> Contractual hold harmless provisions^{xcv} 	HMOs
	<ul style="list-style-type: none"> Must pay for emergency care services^{xcvi} 	Managed care organizations
South Dakota	<ul style="list-style-type: none"> If provider network insufficient, coverage of benefits at no greater cost to the covered person than if the service were provided by a participating provider^{xcvii} Contractual hold harmless provisions^{xcviii} 	Managed care plans (plans operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following: (a) Arrangements with selected providers to furnish health care services; (b) Explicit standards for the selection of participating providers; or (c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan)
Tennessee	<ul style="list-style-type: none"> Contractual hold harmless provisions^{xcix} 	HMOs

State	Code/Rule/Opinion	Entity Regulated
	<ul style="list-style-type: none"> • Non-contracted provider rate the same as non-capitated providers in the network^c - non-contracted provider must disclose a reasonable range of the total charges for non-emergency care if requested and disclose reasonable range of balance billing charges to patient or patient shall not be liable for such charges 	Managed health insurance issuers
Texas	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{ci} • Commissioner shall issue certificate of authority if satisfied that the plan is an appropriate mechanism for provision or arrangement for provision of basic health care services on a prepaid basis except to the extent of reasonable requirements for copayments^{cii} • “Basic health care services” are health care services the Commissioner determines an enrolled population might reasonably need to be maintained in good health^{ciii} • Basic health care services are prescribed in 28 Tex. Admin. Code §§ 11.508 and 11.509^{civ} • Basic health service evidence of coverage shall provide as a basic health care service outpatient services, including emergency services^{cv} • HMOs shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate^{cvi} • Contracts and group certificates must contain provision describing how to obtain services in emergency situations^{cvi} • Application for certificate of authority must include documentation demonstrating that the HMO will pay for emergency care services performed by non-network physicians and providers at the negotiated or usual and customary rate^{cvi} • Application for certificate of authority must include explanation of the adequacy of the physician and other provider network configuration^{cix} • If medically necessary covered services are not available through network physicians or providers, the HMO, on request of a network physician or provider, shall allow referral to a non- 	HMOs

State	Code/Rule/Opinion	Entity Regulated
	<p>network physician or provider and fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate^{cx}</p>	
	<ul style="list-style-type: none"> • A health insurance policy that provides different benefits from basic level of coverage for use of preferred providers and that meets the requirements of Texas Insurance Code Chapter 1301 is not unjust under Chapter 1701; unfair discrimination under Subchapter A or B, Chapter 544; or a violation of Subchapter B or C, Chapter 1451^{cx1} • Insurer offering preferred provider benefit plan shall ensure that both preferred and basic level benefits are reasonably available to all insureds; if preferred provider services are not available, the insurer shall reimburse a non-preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed^{cxii} • Insurer marketing preferred provider benefit plan shall contract with physicians and providers to ensure availability and accessibility to adequate personnel, specialty care and facilities^{cxiii} 	<p>Insurers offering preferred provider benefit plans</p>
	<ul style="list-style-type: none"> • Tex. Ins. Code Ch. 1301 does not limit the level of reimbursement or level of coverage, including copayments, coinsurance, or other cost-sharing provisions, that apply to preferred or non-preferred providers, except as provided by § 1301.0046^{cxiv} • Insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50% of the total covered amount^{cxv} • If insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for specified emergency care services at the preferred level of benefits^{cxvi} • Preferred provider contract must include provision by which 	

State	Code/Rule/Opinion	Entity Regulated
	<p>physician or provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee^{cxvii}</p>	
	<ul style="list-style-type: none"> • Health benefit plans shall: <ul style="list-style-type: none"> - notify enrollees that facility-based physicians or practitioners may not be included in the plan's network and may balance bill - clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the plan's provider network - notify the enrollee in explanation of payment if payment at the plan's allowable or usual and customary amount has been made along with the department's consumer protection division number^{cxviii} 	<p>Health benefit plans that provide health care through a provider network^{cxix}</p>
	<ul style="list-style-type: none"> • Facility-based physicians must make disclosure to patient to include status as non-preferred provider^{cxx} 	<p>Facility-based providers</p>
	<ul style="list-style-type: none"> • Commissioner shall appoint advisory committee to study facility-based provider network adequacy and to advise designated members of the legislative and executive branches concerning its findings^{cxxi} 	<p>n/a</p>
<p>Utah</p>	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{cxxii} <ul style="list-style-type: none"> - non-contracted provider may be able to seek amounts beyond those owed by the plan^{cxxiii} 	<p>HMOs</p>
<p>Vermont</p>	<ul style="list-style-type: none"> • Contractual hold harmless provisions^{cxxiv} 	<p>HMOs</p>

State	Code/Rule/Opinion	Entity Regulated
Virginia	<ul style="list-style-type: none"> Contractual hold harmless provisions^{cxxv} 	HMOs
Washington	<ul style="list-style-type: none"> Contractual hold harmless provisions <ul style="list-style-type: none"> - exceptions for emergency care for non-participating providers, out-of-area services, and in exceptional situations approved by the commissioner in advance, the HMO's inability to negotiate reasonable and cost-effective participating provider contracts 	HMOs
West Virginia	<ul style="list-style-type: none"> Contractual hold harmless provisions^{cxxvi} HMO responsible for normal charges of emergency health care services performed by non-contracting providers^{cxxvii} 	HMOs
Wisconsin	<ul style="list-style-type: none"> Contractual hold harmless provisions^{cxxviii} <ul style="list-style-type: none"> - hospital or provider can opt out by special contractual arrangement^{cxxix} 	HMOs
	<ul style="list-style-type: none"> Specifies network adequacy requirements for providers, specialist providers, OB-GYN services, and emergency care^{cxxx} 	Defined network plans that require an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan.
Wyoming	<ul style="list-style-type: none"> Contractual hold harmless provisions^{cxxxi} 	HMOs

ⁱ Ala. Ins. Code §§ 27-21A-3(b)(4); Ala. Admin. Code § 420-5-6-.10(2)(q).

ⁱⁱ Ala. Admin. Code § 420-5-6.06(12).

ⁱⁱⁱ 3 Alaska Admin. Code §26.110.

^{iv} Ariz. Rev. Stat. §20-1072.

^v *Id.*

^{vi} Ark. Code Ann. § 23-76-119(c).

^{vii} Ark. Code §23-99-604.

-
- viii Ark. Code § 23-98-109.
- ix *Id.*
- x *Id.*
- xi Health & Safety Code §1379.
- xii 28 Cal. Code of Reg. §1300.71(a)(3).
- xiii 28 Cal. Code of Reg. §1300.71.4.
- xiv 28 Cal. Code of Reg. §1300.71.39.
- xv Col. Ins. Code §10-16-704.
- xvi *Id.*
- xvii *Id.*
- xviii *Id.*
- xix *Id.*
- xx *Id.*; Col. Ins. Code §10-16-705(c), §10-16-703(3)(a)(II) and (III).
- xxi Conn. Gen. Stat. §38a-193; Conn. Ins. Code §38a-479bb.
- xxii 18 Delaware Admin. Code Reg. 1403 §7.0.
- xxiii 18 Delaware Ins. Code §§3348, 3564, 3565.
- xxiv 18 Delaware Ins. Code §3349.
- xxv Fla. Ins. Code §641.3154.
- xxvi Fla. Ins. Code §641.513.
- xxvii Fla. Ins. Code §636.214.
- xxviii Georgia Ins. Reg. §120-2-44.04.
- xxix *Id.*
- xxx *Id.*
- xxxi *Id.*
- xxxii Georgia Ins. Reg. §120-2-75.06.
- xxxiii 33 Ins. Code §33-20A-9.1.
- xxxiv 24 Hawaii Rev. Statute §432D-8.
- xxxv IDAPA 18.01.26 §4.
- xxxvi Idaho Ins. Code §41.3915.
- xxxvii *Id.*

-
- xxxviii 215 ILCS 125/2-8.
xxxix 215 ILCS 125/4.5-1.
xl 215 ILCS 125/4-15.
xli 215 ILCS 134/65.
xlii Indiana Ins. Code 27-13-15-1 - 27-13-15-3.
xliii Indiana Ins. Code 27-13-36-5.
xliv Indiana Ins. Code 27-13-36-9.
xlv Iowa Admin. Code §191-40.18.
xlvi Iowa Admin. Code § 191-40.21.
xlvii Iowa Admin. Code §191-27.4.
xlviii *Id.*
xlix *Id.*
l Kansas Ins. Code 40-3209.
li Kansas Ins. Code 40-4607.
lii Kentucky Ins. Code §304.17A-527.
liii R.S. 22:2018.
liv *Id.*
lv *Id.*
lvi R.S. 22:250.44.
lvii *Id.*
lviii Maine Insurance Code 24-A §4204.
lix Maine Insurance Code 24-A §4303.
lx Maryland Code Ann. Health - General § 19-710.
lxi Maryland Code Ann. Health - General § 19-710.1.
lxii Massachusetts Gen. Laws Chap. 176G:21; 211 Code of Massachusetts Regulations 52.12.
lxiii Michigan Insurance Code 500.3529.
lxiv Michigan Insurance Code 500.3517.
lxv Minnesota Insurance Code § 62D.12.
lxvi Mississippi Insurance Code 83-41-325.
lxvii Missouri Insurance Related Laws 354.606.

-
- lxviii Montana Insurance Code 33-36-202.
lxix Montana Insurance Code 33-36-205.
lxx Nebraska Insurance Code 44-7106.
lxxi Nebraska Insurance Code 44-6829.
lxxii Nevada Administrative Code 695C.190.
lxxiii Nevada Administrative Code 695G.175.
lxxiv New Hampshire Insurance Code § 420-J:8.
lxxv New Jersey Administrative Code 8:38-15.2; see also New Jersey Administrative Code 11:24-9.1.
lxxvi New Jersey Administrative Code 11:4-37.3.
lxxvii 13.10.13.25 New Mexico Administrative Code.
lxxviii 13.10.13.11 New Mexico Administrative Code.
lxxix NY Ins. Code § 4804.
lxxx NY Ins. Code § 4805; see also NY Pub. Health Code § 4406-e concerning HMOs and access to end of life care.
lxxxi 10 NY Codes, Rules & Regulations § 98-1.5(b)(6)(2).
lxxxii NY Ins. Law § 3221(l)(15); see also NY Ins. Law §§3216(i)(24) and 4303(aa) for similar provisions concerning payment of emergency ambulance services for individual policies, hospital service corporations.
lxxxiii North Carolina Ins. Code 58-67-115.
lxxxiv 11 North Carolina Administrative Code 12 .0561.
lxxxv North Dakota Insurance Code 26.1-18.1-12.
lxxxvi Ohio Revised Code 1751.13.
lxxxvii *Id.*; see also 17 Ohio Revised Code 1751.60.
lxxxviii 17 Ohio Revised Code 1751.12.
lxxxix Ohio Ins. Code 3923.58.
xc 36 Oklahoma Insurance Code 6913.
xci Oregon Insurance Code 750.095.
xcii 31 Pennsylvania Ins. Regs. § 301.122.
xciii 31 Pennsylvania Ins. Regs § 152.15; see also 40 P.S. 991.2116 and 991.2117 concerning continuity of care following termination of a provider's contract and emergency services with regard to managed care plans..
xciv Rhode Island Insurance Code 27-41-26.
xcv South Carolina Insurance Code § 38-33-130.
xcvi South Carolina Insurance Code § 38-71-1530.
xcvii South Dakota Insurance Code § 58-17C-9.

-
- xcviii South Dakota Insurance Code § 58-17C-14.
- xcix Tennessee Insurance Code 56-32-205.
- c Tennessee Insurance Code 56-32-228.
- ci Texas Insurance Code § 843.361, 28 TAC § 11.901(a)(1).
- cii Texas Insurance Code § 843.082(3).
- ciii Texas Insurance Code § 843.002(2).
- civ 28 Tex. Admin. Code § 11.2(b)(8).
- cv 28 Tex. Admin. Code § 11.508(a)(1)(J).
- cvi Texas Insurance Code § 1271.155(a).
- cvi 28 Tex. Admin. Code § 11.506(10).
- cviii 28 Tex. Admin. Code § 11.204(20).
- cix Texas Insurance Code § 843.078(k).
- cx Texas Insurance Code § 1271.055(b); 28 Tex. Admin. Code § 11.506(15).
- cxii Texas Insurance Code § 1301.003.
- cxii Texas Insurance Code § 1301.005.
- cxiii Texas Insurance Code § 1301.006; see also 28 Tex. Admin. Code § 3.3703(a).
- cxiv Texas Insurance Code § 1301.0045.
- cxv Texas Insurance Code § 1301.0046.
- cxvi Texas Insurance Code § 1301.155(b).
- cxvii Texas Insurance Code § 1301.060; see also 28 Tex. Admin. Code § 3.3703(a)(10).
- cxviii Texas Insurance Code § 1456.003; see also Texas Insurance Code §§ 1456.005 and 1456.006.
- cxix Texas Insurance Code § 1456.003.
- cxx Texas Insurance Code § 1456.004; see also Texas Insurance Code § 1456.005.
- cxxi Texas Insurance Code § 1456.0065.
- cxxii Utah Insurance Code §31A-26-301.5 and 31A-8-407.
- cxxiii Utah Insurance Code §31A-26-301.5.
- cxxiv Vermont T. 8 §5102b(d).
- cxxv Virginia Ins. Code §38.2-5805.
- cxxvi West Virginia Ins. Code §33-25A-7a.
- cxxvii *Id.*

^{cxxviii} Wisconsin Ins. Code §609.91.

^{cxxix} Wisconsin Ins. Code §609.92.

^{cxxx} Wisconsin Ins. Code §609.22.

^{cxxx} Wyoming Ins. Code §26-34-114.