



January 26, 2010

Ms. Susan Nolan
Executive Director
National Conference of Insurance Legislators
385 Jordan Road
Troy, NY 12180

Dear Ms. Nolan,

Thank you for the opportunity to comment upon the above referenced proposed Model Act. The Texas Medical Association ("TMA") is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission statement is to "Improve the Health of All Texans." Its more than 44,000 members practice in all fields of medical specialization. It is located in Austin, Texas and has 119 component county medical societies around the state.

TMA supports the notion that our patients (insurance consumers) deserve information that will enable them to understand the limitations on the benefits offered through insurance policies. Marketing materials from insurers often mention the benefits, but rarely inform our patients about the limitations on those benefits. Senate Bill 1731 (SB 1731) was Texas' attempt to bring transparency to the issue regarding the adequacy of health carrier networks.

We offer the following specific insights on the Draft Model Act:

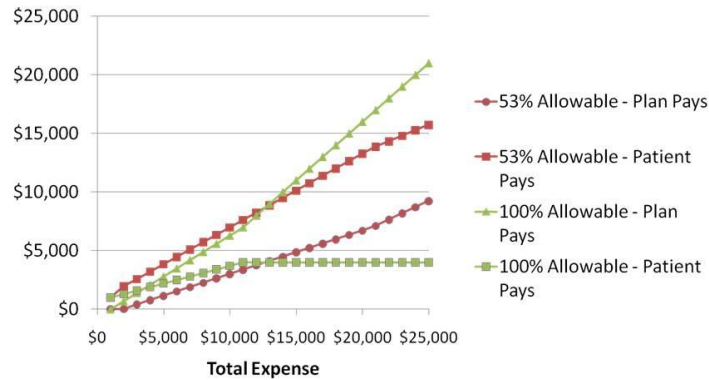
Section 3 of the Model Act; Definitions.

- A. The definition of balance billing should include the phrase "after co-payments, co-insurance, and deductibles" to differentiate between the consumer's acknowledged financial responsibility under their insurance coverage and the amounts left unpaid for which the patient is responsible.

Experience has taught us to be clear on the responsibility imposed by the coverage and the responsibility remaining due to the carriers "allowable" limitation in claims settlement. As you see in the figure below, a carrier which begins calculation of financial responsibility out-of-network at 53% shifts much of the financial burden to patients (insurance consumers). An SB 1731 data call on carriers revealed that one carrier, on the aggregate, set its "allowable" at 53%.

Effect of Plan Allowable on Out-of-Pocket

Assumed: \$1000 deductible, 30% coinsurance with \$3,000 maximum



Section 5 of the Model Act; Facility Disclosure.

This section empowers consumers with the ability to obtain information regarding the facility-based physicians practicing in the facility. Consumers who plan their care for non-emergency services now have the information which enables them to determine the limitations of their insurance network benefit and prepare accordingly.

In reviewing the law, one may notice that four parties take responsibility, in some fashion, to provide patients with information about network benefits. Those parties are: facilities, physicians (and at times specifically facility-based physicians), insurance carriers, and state government. Each party's participation in disclosure was considered essential.

Section 6 of the Model Act; Physician Disclosure.

This section directs facility-based physician practices to standardize their billing procedures. To facilitate the payment of out-of-pocket costs, this section requires discussion of a payment plan when so requested by the patient. This is in the hope that patients will be empowered to formulate appropriate financial plans.

Subsection "C" is from Texas' mediation laws enacted under House Bill 2256. This goes beyond the "transparency" provisions of SB 1731. TMA suggests that should this model encompass Texas' mediation provisions, then the numerous protections from that law (HB 2256) should be reflected.

For example, HB 2256 states that the mediation may be called only by the patient and involves the physician, patient, and carrier. Unlike arbitration between a physician and a health plan only, which health plans prefer, the Texas mediation process provides a venue where the patient is always part of the discussion as it affects his or her financial responsibility under the insurance policy. Carriers' preference for alternative dispute resolution (mediation or binding arbitration) where only the insurance carrier and the physician participate will not advance the notion that patients should be empowered so that they may make more informed decisions about the cost of health care and their insurance purchases.

It is also important to note that mediation is only available for Preferred Provider Benefit Plan coverage and the coverage offered to employees of the state of Texas.

This is because, in Texas, HMOs must hold enrollees harmless and pay an amount necessary to prevent a patient billing for emergency care. In other words, an HMO, as the company that offered pre-paid health care, has a duty to pay for emergency care in order to ensure its enrollees are not billed.

Finally, subsection "D" seems to be redundant as this requires information carriers should already have as a result of their credentialing processes.

Section 7 of the Model Act; Health Benefit Plan Disclosures.

This section of the bill delineates carrier disclosures so that consumers understand their out of network liability under the benefit they have purchased. The written disclosures required are those that most likely attract consumers' attention. The message is repeated in an attempt to lessen any surprise associated with the possibility of being treated by an out-of-network facility-based physician at a network hospital.

The disclosure, although it may be modified by the commissioner, was standardized, under subsection B.2., in order to re-enforce the message and prevent the development of confusing carrier by carrier disclosures.

The requirement to mandate compliant information to consumers as stated in Subsection "E" is critically important. Consumers are entitled to the fair settlement of their health insurance claims. If consumers are angry or displeased about the claim settlement those consumers should know that a remedy is available and be able to access information about how they may file a complaint to the Department of Insurance.

Subsection "G" of the model act contains one of the two Texas transparency law provisions for patient estimates. Texas SB1731, in §101.352(c), requires out of network physicians to provide an estimate of charges. This is synonymous to the carrier mandate to provide the estimate for in-network patient responsibility. .

Section 8 of the Model Act; Penalties.

In this section the party selling the insurance coverage is charged to know the law associated with its product and behave accordingly (and comply).

Physicians, as small businesses, with the little knowledge of the insurance/benefit industry are granted a remedial effort prior to disciplinary action.

General Comments; Governmental Transparency Efforts.

NCOIL members may want to note that SB1731 charged three state agencies with duties regarding transparency in out-of-network circumstances, The Texas Medical Board (which licenses physicians), The Texas Department of Insurance and Texas Department of State Health Services (which licenses hospitals) were all required to create and maintain a "Consumer Guide to Health Care." These consumer guides are intended to educate Texans upon their responsibilities and the limitations of the insurance products they purchase.

Again, thank you for the opportunity to provide insight and commentary.

Sincerely,



Oscar W. Brown III, MD
Chair, TMA Council on Socioeconomics