State Laws Preventing Incentive Programs & Tiered Cost-Sharing

In 2020, the Trump Administration adopted the Transparency in Coverage (TiC) rules. Within the rules, the federal government began allowing insurers to use incentives, such as lower deductibles, as a means of encouraging members to shop for services from higher-value, lower-cost providers. Further, when enrollees take advantage of such incentives, health plans can return part of the savings to consumers and include the "shared savings" in the numerator of medical-loss ratios rules to reduce what they pay in rebates. Unfortunately, state laws and rules currently prohibit insurers from incentivizing patients to use low-cost, high-quality providers. These provisions, often called "Freedom of Choice" rules, prohibit issuers from creating innovative cost-sharing models like lower deductibles, copayments, and coinsurance within the same type of provider class, even if there is significant variation in the negotiated provider prices.

In addition to the Freedom of Choice rules, there are certain obstacles built into the Insurance Code, such as physician tiering laws and quality assessment laws, that prohibit even the sharing of certain quality information that are needed for this type of policy to work. While it is possible to modify or repeal these prohibitions and obstacles, we believe that this policy change would also need to be proactively addressed in statute. To address this issue, the legislature should pass a bill that expressly allows for cost-sharing incentives while also lowering or eliminating the administrative burdens on issuers that would like to provide consumers with the information they need to make informed decisions as they shop for services.

Cost-Sharing Incentives

State law expressly prohibits certain plans from applying different cost-sharing requirements to providers within the same class. For example, preferred provider ("PPO") and exclusive provider ("EPO") plans may not limit the level of reimbursement or level of coverage that are applicable to all preferred (network) or all nonpreferred (non-network) providers.[1] This law, as well as other related laws, was the basis for TDI's Freedom of Choice rule, which requires plans to provide access to all classes of providers, and prohibits insurers from restricting the insured's right to exercise full freedom of choice in selecting a provider.[2] This is by far the biggest barrier to incentive programs, and in order to fully address the issue, a bill should plainly state that issuers may incentivize the use of certain providers through cost-sharing mechanisms. This provision would need to be a carveout to the law cited above.

[1] Tex. Ins. Code Sec. 1301.0045.
[2] 28 TAC 3.3704.

Physician Tiering Laws

Pursuant to the Insurance Code,[3] health plans may not rank, classify into performance tiers, or publish physician-specific comparisons against standards, measures, or other physicians, unless:

- Standards used by the plan are transparent and valid, have physicians in clinical practice actively involved in their development, and follow national standards.
- Standards are disclosed to all physicians before any evaluation period.
- Plans provide at least 45 days advance written notice before publication and offer each physician a burdensome appeal process that allows an in-person "reconsideration proceeding."

Many health plans simply find these requirements too burdensome, and therefore forego sharing quality information entirely. If a bill were to allow cost-sharing incentives, this barrier to sharing quality information should be pared back dramatically or eliminated entirely. If the bill was passed without changing this law, plans could create incentives but would not be able to share with the patient why they may want to consider a high-quality provider over another.

Quality Assessment Laws

PPO/EPO plans may not engage in quality assessment except through a panel of at least three network physicians.[4] The physicians must be selected by the insurer from a list of physicians contracting with the insurer. The list of physicians must be provided by physicians contracting with the insurer in the applicable service area. Like the physician tiering laws, this puts an additional burden onto plans that would like to assess the quality of physicians and share that information with members. While it is important to have physicians conducting such reviews, health plans already have physicians on staff that are fully capable of doing so. This requirement to use only physicians from a list provided by physicians in the area is administratively too difficult to achieve.

Anti-Rebate Laws

Issuers cannot give anything of value not specified in the policy as an inducement to enter into a health insurance policy.[5] Further, any such benefit that is provided within the policy must be reasonably related to the type of policy or certificate being offered.[6] While this may not directly prohibit incentive programs and tiered cost sharing after an individual has purchased a policy, it may be helpful to provide a clarification within this law that doing so would not violate its provisions.

Prohibition on Capitated Payments

As it currently stands, only state-regulated HMOs can enter into value-based contracts for capitated rates. For example, state-regulated PPO/EPO plans and self-funded

[3] Tex. Ins. Code Ch. 1460.
[4] Tex. Ins. Code Sec. 1301.059.
[5] Tex. Ins. Code Sec. 541.056, 543.003.
[6] Tex. Ins. Code Sec. 1701.061.

ERISA plans cannot pay a primary care physician a flat, monthly payment for direct primary care or advanced primary care. Under a fee-for-service model, there is an incentive for the physician to provide as many services as possible; under a capitation model, the physician is incentivized to keep patients as healthy as possible so that the amount of care they provide does not exceed the flat fee paid by the insurer. If the state is going to allow incentive programs and tiered cost sharing, also allowing capitated payments would maximize the utility and effectiveness of the new incentive programs. To do that, the law would have to expressly state that both self-funded ERISA plans and PPO/EPO plans can enter into value-based and capitated payment arrangements.