TAHP
The Texas Association of Health Plans

Texas Association of Health Plans
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April 11, 2023

Dear Chairman Oliverson and Members of the House Insurance Committee,

Re: HB 3359

TAHP is opposed to the legislation as filed but is working with stakeholders and the bill author's office to address any unintended consequences. Our primary concern is related to the sections of the bill that would create a state-mandated cap for out-of-network out-of-pocket costs and combining it with in-network out-of-pocket costs. Instead of having different limits on what a patient has to pay out-of-pocket for in-network or out-of-network care, those will be the same, and that will increase premiums dramatically.

This unprecedented mandate goes beyond the Affordable Care Act and will dramatically increase premiums. In order to have plan options with affordable premiums and out-of-network coverage, health plans design products that set different in-network and out-of-network cost sharing amounts for preferred provider benefit plans (PPOs). While the Affordable Care Act (ACA) caps out-of-pocket costs for in-network care, there is no cap for out-of-network care.

We caution against the approach outlined in HB 3359, as it will increase premiums substantially for the typical health plan design that employers choose and move the market to HMO/EPO products that have no out-of-network coverage. These provisions eliminate the flexibility in benefit designs that employers select to control costs. The overall effect of this part of the bill will be increases in premiums for PPO products, making them unattractive to employers.

Premiums would increase because the bill would permit enrollees to seek care from out-of-network providers, and would require the health plan to count any payment towards their out-of-pocket maximum, regardless of whether the care was medically necessary or cost effective. After the out-of-pocket maximum is met, enrollees would have no incentive to shop for lower-cost options. Because the insurer would be required to fully reimburse these expensive services, a significant amount of new costs would ultimately be passed to other enrollees through increased premiums or cost-sharing.

Typically, employers choose PPO plans with a high out-of-network out-of-pocket max (if not unlimited) and a lower in-network out-of-pocket max to keep premiums lower but still have an

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out-of-network benefit. As an example, coverage for elected officials through ERS has an in-network out-of-pocket cap of $2,000 and an out-of-network cap of $7,000. TAHP is concerned that the impact of this legislation will be employers moving to plans that only have in-network benefits (HMOs & EPOs). We would expect further erosion in the small group coverage market where less than 50% of employers with 50 or less employees offer health plans.

TAHP welcomes increased scrutiny on the network adequacy waiver process, including more transparency and making information on what rates providers and insurers are requesting and offering publicly available. However, TAHP cautions against changes to the network adequacy process that can amplify the harms of anti-competitive market share, consolidation, and resulting higher prices. Network adequacy standards must be realistic and achievable, and access waivers need to be allowed when providers are unavailable.

For example, 77 of the state's 254 counties have no hospital. In order to offer a health benefit plan in those counties, a waiver is required. Waivers must also be available when provider groups simply refuse to contract or demand excessive rates. Importantly, Texas is ground zero for extreme provider consolidation. Private equity firms have entered our state and amassed anti-competitive market share through physician staffing firms. For example, in Austin, one ER staffing firm controls over 80% of emergency department care (see Appendix A). In Houston, one anesthesia staffing firm controls at least 70% of all anesthesia services. Of the 19 Texas metro areas, 95% have highly concentrated hospital markets.

Texas already has network adequacy standards that are often impossible to achieve. In fact, the state's largest health plan, operating in all 254 counties, with nearly all Texas providers in-network, still needs 84 access waiver in order to operate. This demonstrates that it is not possible to avoid waivers simply by having more providers in-network.

If health plans are unable to reasonably obtain a waiver, Texas non-urban counties should expect to have fewer or no coverage options available, as health plans cannot sell coverage without an adequate network or waiver. The waiver process requires plans to demonstrate how a patient will still have access and will be held harmless from out-of-network costs. These are important protections, and the Texas Department of Insurance (TDI) heavily scrutinizes access plans. In most cases, waivers are resolved by identifying providers outside of the service area that patients can access. For example, pointing to specialty providers that only exist in urban hubs.

HB 3359 makes several changes to network adequacy processes, waiver approvals, and plan benefit design that would have a net effect of reducing health plan availability in non-urban

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areas, increasing premiums for preferred provider benefit plans, and reducing health plan competition through significant market entry challenges for smaller plans and new market entrants.

Specific Concerns and Suggestions:

1) **Health plans should be able to negotiate fair and affordable rates**. New network adequacy standards currently proposed in the bill will be difficult or impossible to achieve. For example, the bill would require plans to ensure that every hospital and ambulatory surgery center has a neonatologist on staff. Only 70 of the 163 rural hospitals provide obstetrical care and deliver babies, much less offer neonatology specialty care. The bill should be amended to ensure that the network access standards are achievable and ensure that plans can reasonably receive a waiver when these standards are impossible to achieve.
    - **Account for anti-competitive market share:** The waiver process must also account for the significant market dominance of certain provider groups and the leverage these hospital systems and provider groups have in contract negotiations. The state should not be forcing contracts at excessive network rates. Making waivers less accessible will create pressure to accept contract terms at higher than market rates. The result will be higher premiums and less health insurer market participation.
    - **Ensure waivers can still be reasonably obtained:** We are concerned about undefined terms in the bill including "good cause" and "good-faith" efforts. We recommend that all information related to waivers, including rates requested by the provider, rates offered by the insurer, and market share of the provider, be made public. Health plans must still be able to obtain waivers when there is a contract dispute with providers.
    - **Public hearings upon request only:** While we do not oppose public hearings for contracting disputes that result in waivers, we believe these should only be at the request of a provider that feels the health insurer was unfairly given a waiver.
    - **Remove language requiring multiple specialties in all facilities:** The bill requires a sufficient number of network providers of emergency medicine, anesthesiology, pathology, radiology, neonatology, surgery, hospitalist, intensivist and diagnostic services, including radiology and laboratory services at each

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network hospital, ambulatory surgical center or freestanding emergency medical care facility. Many facilities, especially non-urban facilities, will not have one or more of these provider types available to contract with. Again, the impact of this provision as written will be an exodus of health plans and reduced competition in non-urban areas.

2) **Network adequacy standards should treat rural and non-urban areas differently.** There must be some recognition that these standards are unachievable in much of the state. Over 30 counties in Texas have no physician and much of the state is considered a health professional shortage area. Health plans competition has been steadily growing in the state and more rural areas are seeing multiple insurer options. However, waivers are required to operate in these areas. Creating added administrative burden for these waivers will create a disincentive for health plans to operate in rural areas. We are unsure of the value of a public hearing on a waiver request where no providers are available.
    - **Exempt waivers from public hearings for no provider availability:** Most waivers are for service areas where providers simply do not exist. Having a public hearing on each of these waivers is administratively expensive and unnecessary. Health plans will make the decision to forgo operating in non-urban counties with few enrollees as the administrative costs will not be financially viable.
    - **Adopt time and distance standards that better reflect rural Texas:** We believe the time and distance standards in the bill reflect federal standards that do not account for the vast, rural nature of our state. We suggest adopting more achievable standards or making it less onerous to achieve a waiver for the simple reason that no provider is available to contract.

3) **Ensure market opportunity for small health plans and new market entrants.** We are concerned about the viability of smaller health plans and new market entrants to meet the requirement to operate in a complete trauma service area. For example, a new health plan offering coverage in the large group market recently entered North Texas. The insurer chose a five county service area—Dallas, Denton, Collin, Rockwall and Tarrant. Under this legislation the insurer would be required to immediately offer coverage in the other 14 counties in that trauma service area, potentially forcing the insurer to exit Texas.
    - **We recommend removing the requirement that health plans operate in a complete trauma service area.** This requirement would discourage market entry

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by new and innovative health insurers that are looking to expand to Texas as well as existing health plans that operate in smaller services areas.

- **Restrict waiver request hearings to contract disputes and provider requests**. Requiring health insurers to expand to rural areas and requiring onerous waiver hearings when no provider is available sets up competing interests. If we want health plans to move to more rural areas we should not make this more difficult.

4) **Reconsider a single out-of-pocket maximum for in and out-of-network care.** The legislation makes an untested and unprecedented change to health benefit design by requiring preferred provider plans (PPOs) to have a single out-of-pocket maximum for both in-network and out-of-network care. Additionally, the legislation sets this cap at an undefined "reasonable amount." While TAHP does not oppose efforts to encourage patients to shop for lower cost care options and have those costs apply to in-network out-of-pocket limits, the bill's approach would have significant negative consequences. In order to have plan options with affordable premiums and out-of-network coverage, health plan design sets up varying in-network and out-of-network cost sharing amounts for PPOs. While the Affordable Care Act (ACA) caps out-of-pocket costs for in-network care, there is no subsequent cap for out-of-network care. This proposed mandate would exceed the ACA and result in significant premium increases for PPO plans.
    - **We recommend removing the bill's untested requirement for a single in and out-of-network out of pocket maximum.** One large plan in Texas estimates that the impact of this proposal would be an increase in premiums of 2.7%. Roughly, that's an increase in premiums of $270 million per year. TAHP has asked for an independent analysis of the impact of this provision in the legislation. The small group coverage market is very sensitive to premium increases and TAHP anticipates a move away from PPO plans with out-of-network benefits to HMO or EPO plans with no out-of-network coverage.
    - **We would not oppose a requirement to apply out-of-network care amounts to in-network cost sharing with certain guardrails.** Patients should be encouraged to shop for lower cost care. If patients identify shoppable covered services at lower than in-network rates, we would not oppose this requirement.

5) **Remove provisions related to adverse contract decisions:** This section would prohibit any "adverse material changes" to a preferred provider contract during the term of the

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contract unless there was mutual agreement of the parties. Contracts between health plans and providers currently have mutual termination clauses, meaning either party can leave the contract at will. Under this provision, a provider would still be able to leave a contract, for example in an attempt to force higher rates, but a health plan would be prohibited from doing the same. We would anticipate this provision would result in shorter contract terms versus the typical longer contract terms available now. That way, contract terms can be renegotiated at the end of the term. This creates an unnecessarily cumbersome contracting environment. We are also concerned about the impact on competition. If new provider groups form with higher quality lower cost services, health plans could not adjust networks to reflect these new provider types, essentially shielding providers from competition. This section of the bill also creates a 120-day delay in implementation of contract changes, even those that are mutually agreed upon.

- **Clarify that "termination" is not considered an "adverse event."** There is no other industry where we lock a party into a contract and termination is an option for both parties. It is unlikely a court would uphold this sort of mandatory specific performance.
- **Remove the 120 day lag time on agreed-to contract changes.** We do not see value in delaying the implementation of agreed-to contract changes.

Texas health plans welcome discussions about improving our network adequacy waiver process, furthering transparency in market negotiations, and encouraging patients to shop for lower-cost care, even if it is out-of-network. However, we are concerned that the provisions of HB 3359 will take the state in the direction of less health plan competition, higher prices for in-network care, and more narrow plan options.

Sincerely,

Jamie Dudensing

Jamie Dudensing, RN
CEO
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