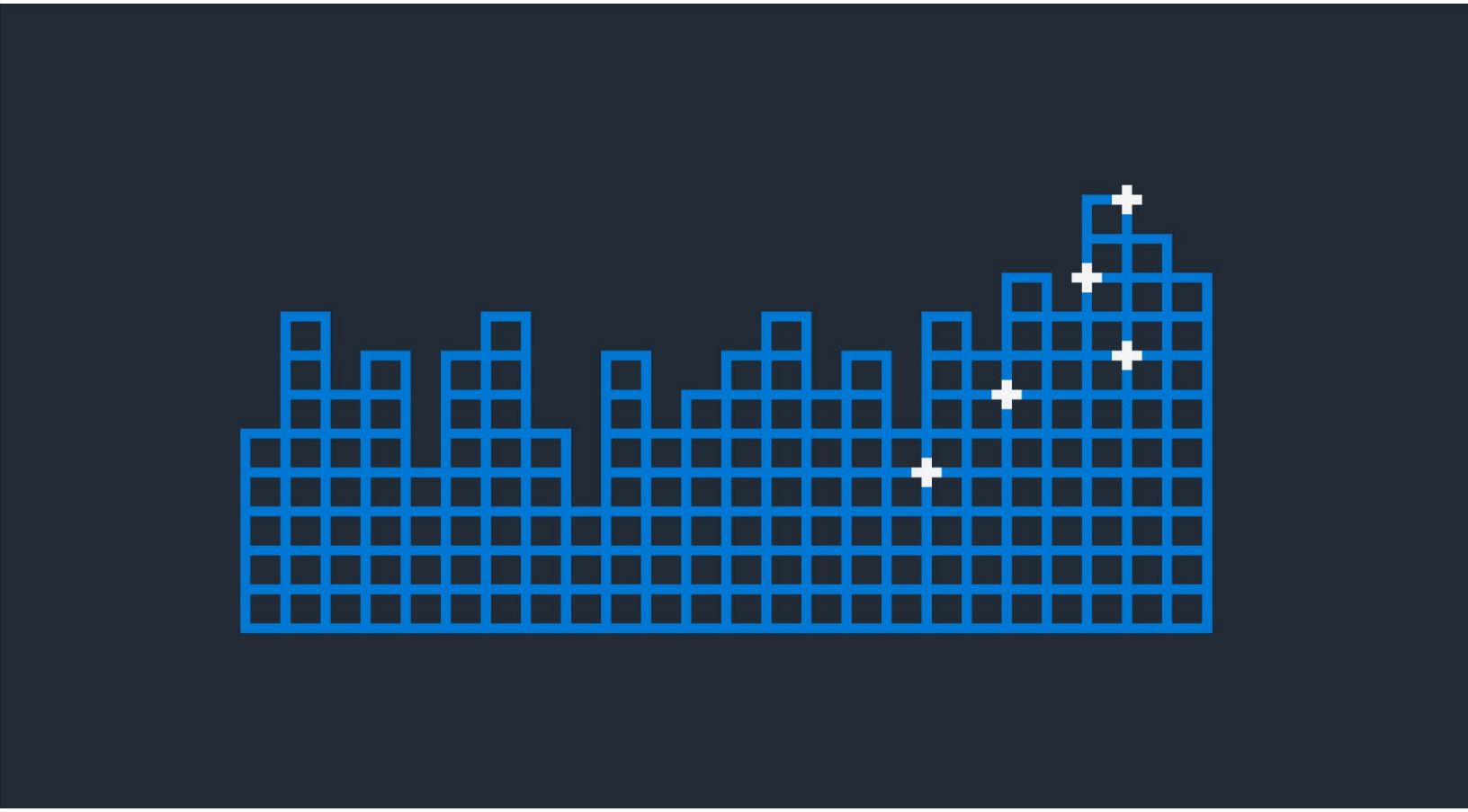
MILLIMAN REPORT

Analysis of Texas HB 4893 and HB 4772/SB 2442, “Any Willing Provider”

Commissioned by the Texas Association of Health Plans

April 14, 2023

Darin Muse, FSA, MAAA
Matt Caverly, FSA, MAAA
Addison Luria-Roberson



Milliman

Table of Contents

Background

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, Medicaid plans, Medicare Advantage plans, and other related healthcare entities operating in the state of Texas. The 88th Texas Legislature is currently in session and TAHP engaged Milliman to provide actuarial support in evaluating some of the proposed bills that could impact the commercial[1] health insurance market in Texas. There are two related any-willing-provider (AWP) bills that are the focus of this report:

1. HB 4893 (Bonnen):[2] This bill requires issuers of health insurance in Texas, including in Medicaid and the Children's Health Insurance Program (CHIP), to contract with any hospital upon its request. The issuer would be required to reimburse the hospital at a rate of 90% of the highest contracted rate for the same service.
2. HB 4773/SB 2442 (Bonnen/Perry):[3] This bill requires issuers of health insurance in Texas, including in Medicaid and CHIP, to contract with any physician upon their request. The issuer would be required to reimburse the physician at a rate of 90% of the highest contracted rate for the same service.

TAHP has requested that Milliman study the potential impact these bills could have on commercial market insurance premiums in Texas.

Any-willing-provider laws are regulations that require health insurers to allow healthcare providers who meet certain criteria to participate in their networks. Under most AWP laws, insurers cannot exclude healthcare providers who meet the standards for their network as long as the provider is willing to accept the insurer's payment rates. However, HB 4893 and HB 4773/SB 2442 build on typical AWP laws by requiring insurers to reimburse the hospital or physician at 90% of the highest contracted rate for the same service.

In addition to increased volume, providers might be interested in being included as participating providers to maximize payments on a per-service basis. Many plans have provisions where they pay out-of-network providers a maximum allowable charge or a usual, customary, and reasonable (UCR) rate. Historically providers have then been able to bill the patient for the balance of the billed charges, though that changed in 2020 due to the passage of SB 1264[4] and the No Surprises Act.[5]

Executive Summary

The immediate impact of these bills would likely only affect out-of-network (OON) claims, as hospitals and physicians not in an insurer's network would likely ask to be included as participating providers pursuant to these bills. There could also be a ripple effect in subsequent years as any hospital or physician who has a contracted rate that is less than 90% of the maximum rate for a given service would be incentivized to terminate its contract and be included as a participating provider pursuant to this law.

To assess these two bills, we modeled the impact on member premiums in the commercial market under several scenarios where facilities and physicians terminate their contracts at varying levels:

1. Assuming all OON reimbursements are now made at 90% of the highest contracted (in-network) rate. This scenario assesses the impact of the bill, as written, without assuming any changes to provider network participation behavior. Note that all other scenarios include this impact as well.
2. Assuming all in-network reimbursements that fall below the 25th percentile of cost at the service level will now be reimbursed at 90% of the highest contracted (in-network) rate. This is intended to simulate the impact of providers receiving the lower quartile of payment rates now operating as any-willing-providers.
3. Assuming all in-network reimbursements that fall below the 50th percentile of cost at the service level will now be reimbursed at 90% of the highest contracted (in-network) rate. This is intended to simulate the impact of providers receiving payments below the median rate now operating as any-willing-providers.

[1] The commercial health insurance market is comprised of insurance provided by nongovernmental entities, typically to a population under age 65.
[2] Full text found at: https://capitol.texas.gov/tlodocs/88R/billtext/pdf/HB04893I.pdf.
[3] Full text found at: https://capitol.texas.gov/tlodocs/88R/billtext/pdf/HB04773I.pdf.
[4] Full text found at: https://capitol.texas.gov/tlodocs/86R/billtext/html/SB01264F.htm.
[5] More information available at https://www.cms.gov/nosurprises.

4. Assuming all in-network reimbursements that fall below the benchmark of 90% of the highest contracted (in-network) rate are now reimbursed at that level. This is intended to represent an extreme scenario simulating the impact of providers receiving payments below 90% of the highest contracted rate now operating as any-willing-providers.

Additionally, we have modeled the impact of each of the bills in isolation and combined. The table in Figure 1 shows a range of the expected impact on commercial premiums under each scenario above.

Figure 1: Impact on Commercial Premiums

		Premium Impact		
Scenario	**Scenario Description**	**HB 4893**	**HB 4773/SB 2442**	**Both Bills**
1	All OON claims paid at 90% of max in-network rate	0% - 1%	1% - 2%	1% - 3%
2	S1 + bottom 25% of in-network contracts move to AWP	7% - 8%	13% - 14%	20% - 22%
3	S1 + bottom 50% of in-network contracts move to AWP	9% - 11%	21% - 22%	29% - 33%
4	S1 + all contracts below 90% of max move to AWP	9% - 11%	28% - 29%	37% - 41%

We estimate that the initial impact of the bills, as written, could be a 1% to 3% increase in premiums in the commercial market. This impact would be felt by both employers and employees. As soon as in-network providers begin to terminate their contracts to operate as any-willing-providers, the magnitude of the impact increases rapidly.

Results

To assess the impacts of these bills on premiums in the commercial insurance market, we first assessed the impact on paid claims by broad service category. We then used the Milliman Health Cost Guidelines™ (HCGs) to determine the average amount of total healthcare spend that each category represents. These bills affect the reimbursement levels for facility and physician claims only and there is no expected impact on pharmacy claims.

SCENARIOS 1-4: AWP REIMBURSED AT 90% OF MAXIMUM CONTRACTED RATE

The first scenario assumes no behavior change by providers as a result of the bills. The table in Figure 2 shows the build-up to an estimated premium impact under each bill in isolation and combined. The low and high estimates are not intended to be a minimum and a maximum but rather represent a reasonable range based on our analysis. These estimates have been rounded to the nearest percentage to indicate the level of implied precision.

Figure 2: Premium Impact Under Scenario 1 – OON Care Reimbursed at 90% of Maximum Contracted Rate

Service category	**Percent of total claims**	**Low estimated increase under this scenario**	**High estimated increase under this scenario**
Inpatient Facility	14.0%	0%	1%
Outpatient Facility	17.4%	1%	3%
Professional	34.7%	4%	4%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		0%	1%
Total impact if only the physician bill passes		1%	2%
Total impact if both bills pass		1%	3%

There is no expected increase to prescription drug costs from these bills, but they account for roughly a third of total expected commercial insured costs. This helps dampen the effect of the bills somewhat. A small proportion of care

takes place out-of-network in Texas, but the increase in costs to have that care reimbursed at 90% of the max contracted rate increases claim costs significantly, even for some out-of-network providers.

Scenario 2 accounts for some behavior change from providers as they begin to terminate their contracts and operate as any-willing-providers. In this case, any provider with a contract in the lowest quartile of reimbursement will terminate its contract. The table in Figure 3 shows the build-up to an estimated premium impact under each bill in isolation and combined

Figure 3: Premium Impact Under Scenario 2 – Scenario 1 + Bottom Quartile of In-Network Providers Shift to AWP

Service category	Percent of total claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	11%	19%
Outpatient Facility	17.4%	29%	29%
Professional	34.7%	38%	40%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		7%	8%
Total impact if only the physician bill passes		13%	14%
Total impact if both bills pass		20%	22%

This scenario has a much more substantial impact on premiums; insurers are losing providers on a contracted basis and with whom they have the best contracts, and are now paying them on an AWP basis, i.e., 90% of the highest contracted rate.

Scenario 3 demonstrates an even larger effect, where all providers with contracted rates below the median terminate their contracts and operate as any-willing-providers. The table in Figure 4 shows the build-up to an estimated premium impact under each bill in isolation and combined.

Figure 4: Premium Impact Under Scenario 3 – Scenario 1 + Bottom Half of In-Network Providers Shift to AWP

Service category	Percent of total claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	15%	26%
Outpatient Facility	17.4%	37%	40%
Professional	34.7%	60%	64%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		9%	11%
Total impact if only the physician bill passes		21%	22%
Total impact if both bills pass		29%	33%

Finally, scenario 4 demonstrates an extreme scenario where all providers who are being reimbursed below 90% of the maximum contracted rate terminate their contracts and operate as any-willing-providers. The table in Figure 5 shows the build-up to an estimated premium impact under each bill in isolation and combined.

Figure 5: Premium Impact Under Scenario 4 – Scenario 1 + All In-Network Providers Under 90% of Maximum Rate Shift to AWP

Service category	Percent of total claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	17%	28%
Outpatient Facility	17.4%	40%	43%
Professional	34.7%	83%	84%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		9%	11%
Total impact if only the physician bill passes		28%	29%
Total impact if both bills pass		37%	41%

SCENARIOS 5: MEDIAN AWP MODELING

In addition to scenarios 1-4, TAHP asked that we model the impact of an AWP provision that assumes all OON claims will be reimbursed at the median of in-network rates. Additionally, we assumed that a provider would only apply to participate per Sec. 1462.003 of these bills if it would increase their average reimbursement levels. The table in Figure 6 shows the build-up to an estimated premium impact under each bill in isolation and combined.

Figure 6: Premium Impact Under Scenario 5 – Median AWP Provision

Service category	Percent of total claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	0%	1%
Outpatient Facility	17.4%	0%	1%
Professional	34.7%	0%	1%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		0%	1%
Total impact if only the physician bill passes		0%	1%
Total impact if both bills pass		0%	2%

The effect of this scenario is much smaller because very few out-of-network providers would be receiving a higher level of reimbursement at the median of in-network levels than if they remained out-of-network. However, an any-willing-provider law of any kind does deteriorate provider networks and limits the ability of insurers to manage care and costs.

SCENARIOS 6-8: AWP REIMBURSED AT 50% OF MAX CONTRACTED RATE

TAHP requested that we model three additional scenarios where a provider would be reimbursed at 50% (rather than 90%) of the maximum contracted rate. The table in Figure 7 shows the impact on commercial premiums for these three scenarios.

Figure 7: Impact on Commercial Premiums

		Premium Impact		
Scenario	Scenario Description	HB 4893	HB 4773/SB 2442	Both Bills
6	All OON claims paid at 50% of max in-network rate	0% - 1%	0% - 1%	0% - 2%
7	S6 + bottom 25% of in-network contracts move to AWP	2% - 3%	4% - 5%	5% - 8%
8	S6 + all contracts below 50% of max move to AWP	2% - 3%	10% - 11%	12% - 13%

Scenario 6 is a repeat of scenario 1, but with a different contracting rate. In this scenario, all OON claims are now reimbursed at 50% of the in-network max. The table in Figure 8 shows the build-up to an estimated premium impact under each bill in isolation and combined.

Scenario 7 is a repeat of scenario 2 with claims repriced to 50% of the in-network max. The table in Figure 9 shows the build-up to an estimated premium impact under each bill in isolation and combined.

Finally, scenario 8 is a repeat of scenario 4, where all contracts below the AWP level are terminated and those providers operate as any-willing-providers. The table in Figure 10 shows the build-up to an estimated premium impact under each bill in isolation and combined.

Figure 8: Premium Impact Under Scenario 6 – OON Care Reimbursed at 50% of Maximum Contracted Rate

Service category	Percent of total claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	0%	1%
Outpatient Facility	17.4%	0%	1%
Professional	34.7%	1%	2%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		0%	1%
Total impact if only the physician bill passes		0%	1%
Total impact if both bills pass		0%	2%

Figure 9: Premium Impact Under Scenario 7 – Scenario 6 + Bottom Quartile of In-Network Providers Shift to AWP

Service Category	Percent of Total Claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	2%	4%
Outpatient Facility	17.4%	9%	10%
Professional	34.7%	11%	12%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		2%	3%
Total impact if only the physician bill passes		4%	5%
Total impact if both bills pass		5%	8%

Figure 10: Premium Impact Under Scenario 8 – Scenario 6 + All In-Network Providers Under 50% of Maximum Rate Shift to AWP

Service category	Percent of total claims	Low estimated increase under this scenario	High estimated increase under this scenario
Inpatient Facility	14.0%	2%	5%
Outpatient Facility	17.4%	11%	12%
Professional	34.7%	28%	31%
Prescription Drugs	33.9%	N/A	N/A
Total impact if only the hospital bill passes		2%	3%
Total impact if only the physician bill passes		10%	11%
Total impact if both bills pass		12%	13%

Data and Methodology

DESCRIPTION OF DATA

Milliman maintains the Milliman Health Cost Guidelines (HCGs), which incorporate more than 60 years of research and consulting practice and are considered the industry gold standard for modeling detailed healthcare utilization. We used our detailed claims database, the Consolidated Health Cost Guidelines Source Data (CHSD), to develop these estimates. We limited it to commercial claims in the state of Texas and used data from calendar years 2018 and 2019, as we believe the pre-COVID-19 levels of utilization best reflect what will be seen going forward.

We excluded claims with zero reported allowed charges, zero units, missing membership attributions, or invalid eligibility records. After applying these exclusions, the data contains detailed claims records for an average of 3.2 million lives per year.

DATA SEGMENTATION

We performed our analysis in three parts based on type of service: inpatient facility, outpatient facility, and professional services. Miscellaneous services such as durable medical equipment and ambulance services are included under professional services. We used these splits due to the many differences in how they are reimbursed, their coding practices, and the cost of services between settings.

We examined the distribution of reimbursement rates for medical services at a provider level to determine the percentile in which each provider's contracts fell. This informs under which circumstances a given provider might look to terminate its contract and operate as an any-willing-provider.

Professional services

For professional services, we determined the contract level to be a grouping by incurred year, provider identification number, metropolitan statistical area (MSA), and specialty. Provider IDs in our data are not the National Provider ID (NPI), but rather a deidentified field that represents a link between provider and data contributor (health plan). The contract level was set this way because this is how we expect a provider might be able to change contracts. Providers would not be able to recontract on a service-by-service basis.

After grouping at this level, we excluded any groupings that did not have 30 claims or more. We kept about 80% of total dollars statewide after this exclusion. This avoids outlier contracts with low credibility.

Next, we calculated the average commercial reimbursement as a percentage of the Medicare fee schedule at the contract level, using only in-network claims. We then calculated percentiles, grouped by year, MSA, and specialty. These percentiles are intended to represent the prevailing contracts in an area that would be available to a provider looking to terminate a contract and start as an AWP.

Contracts were repriced to 90% (or 50% for scenarios 6-8) of the max prevailing rate in that year, area, and specialty, depending on the scenario. We used the 90th percentile as the max level as rates above that were outliers that skewed the results. Additionally, we did not reprice claims for office-administered drugs or anesthesia as those claims also often had outlier reimbursement levels.

Inpatient and outpatient facility services

For inpatient and outpatient facility services, we determined the contract level to be a grouping by incurred year, provider ID, MSA, and place of service (POS). As with professional claims, provider IDs represent a link between a provider and data contributor. We recognize that some facilities can contract on a diagnosis-related group (DRG) basis rather than at a full POS level. As such, our analysis is conservative in the number of contracts that get repriced to higher levels.

After grouping at this level, we excluded from our analysis any groupings that did not have 30 claims or more. We kept about 80% of total dollars statewide after this exclusion. This avoids outlier contracts with low credibility

Next, we calculated the average reimbursement as a percentage of Medicare at the contract level, using only in-network claims. We then calculated percentiles, grouped by year, MSA, and POS. These percentiles are intended to

represent the prevailing contracts in an area that would be available to a provider looking to terminate a contract and start as an AWP.

Contracts were repriced to 90% (or 50%) of the max prevailing commercial rate in that year, area, and POS, depending on the scenario. We used the 75th percentile as the max level as rates above that were outliers that skewed the results.

Methodology limitations

There are some limitations to our approach as we were bound by time and data constraints. For professional claims, we approximated the contract level because we were not able to use NPIs, which roll up to provider group IDs. For facility claims, we approximated the contract level because we were not able to use NPIs, which roll up to hospital type.

It was not feasible to view and remove all outlier contracted rates so our methodology attempts to account for this by using the 90th percentile of in-network rates as the maximum in-network rate for professional claims and the 75th percentile rate as the maximum in-network rate for facility claims.

Furthermore, we are simplifying by treating all contracts as a percentage of Medicare reimbursements as it is not feasible to determine the actual method of contracting on a claim-by-claim basis.

We have not modeled how this will affect different types of plans such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs). The modeled effect is shown for the Texas commercial market as a whole. The actual effect will vary across all plans based on factors such as benefit levels, existing network, and the current level of OON utilization.

Caveats and Limitations

Milliman maintains a claims database (CHSD) that was used to develop this work. We have not audited the data, and if the underlying data or information is inaccurate or incomplete, the estimates produced herein may likewise be inaccurate or incomplete.

Differences between projections and actual amounts will depend on the extent to which future experience conforms to the assumptions used for the projections. There is a substantial amount of uncertainty, including but not limited to: provider contracted rates, insured utilization, behavior change by providers and insureds, and changing regulations. It is certain that actual experience will not conform exactly to assumptions made for these items.

This report is intended to estimate the impact of certain portions of Texas HB 4893 and HB 4773/SB 2442. It may not be appropriate and should not be used for other purposes. Milliman does not intend to benefit or create a legal duty to any recipient of this work.

This information is subject to the existing Consulting Services Agreement between TAHP and Milliman dated March 27, 2023.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Darin Muse and Matt Caverly are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

The authors would like to thank Fritz Busch for his peer review of this material.

Milliman is among the world's largest providers of actuarial, risk management, and technology solutions. Our consulting and advanced analytics capabilities encompass healthcare, property & casualty insurance, life insurance and financial services, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Darin Muse
darin.muse@milliman.com

Matt Caverly
matt.caverly@milliman.com

Addison Luria-Roberson
addison.luria-roberson@milliman.com