TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

January 9, 2015

Ms. Debra Diaz-Lara
Director, Managed Care Quality Assurance Office
Financial Regulation Division
Texas Department of Insurance
Via email: MCQA@tdi.texas.gov

Re: Informal Working Draft of Rules Relating to Chapter 11 HMO Rules Update
(i.e., Title 28 Texas Administrative Code Chapter 11)

Dear Ms. Diaz-Lara:

The Texas Medical Association ("TMA") appreciates this opportunity to comment on the Texas Department of Insurance's ("TDI" or "the Department") new informal working draft rules relating to Health Maintenance Organizations ("HMOs").

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 is to "Improve the health of all Texans." Its more than 49,000 members practice in all fields of medical specialization.

As the Department takes on the daunting task of reviewing and updating Title 28 Texas Administrative Code Chapter 11 in its entirety for the first time in 10 years, TMA appreciates the Department's willingness, as stated at the HMO TDI stakeholder meeting on December 12, 2014, to consider stakeholder comments submitted both on and after the informal comment deadline of January 9, 2015.

In order to provide detailed and focused comments on an issue of critical importance to Texas consumers, this letter is limited to the initial comments of the ***Texas Medical Association and the undersigned Associations (hereinafter collectively, "TMA")*** concerning the Department's informal working draft provisions relating to HMO network adequacy (i.e. Sections 11.1607 through 11.1611). The Texas Medical Association will supplement this letter at a later date with additional comments on the remainder of the informal working draft rule proposal.

I. General Comments on the Network Adequacy Provisions of the HMO Rule Proposal

As the Department is aware, TMA has a well-demonstrated interest in ensuring that patients/consumers obtain value for their premium dollars through the creation of adequate networks for all managed care products utilizing networks in Texas. To this end, TMA previously submitted hundreds of pages of comments on the TDI informal and formal rule proposals regarding network adequacy in the context of preferred provider benefit plans (PPBPs) and exclusive provider benefit plans (EPBPs).

After a lengthy and hard-fought battle to retain many of the PPBP network adequacy consumer protections initially adopted by Commissioner Geeslin on May 19, 2011[1] and subsequently proposed for deletion by Commissioner Kitzman, much progress has been made in creating, ***for the first time ever***, network adequacy standards and regulations applicable to PPBPs in Texas, as well as applicable to the newly-authorized commercial product of EPBPs.[2] The current network adequacy rules applicable to PPBPs and EPBPs became effective on February 21, 2013;[3] however, those rules are merely a ***starting point*** in an effort to ensure that health plans begin meeting consumer expectations and fulfilling their statutory obligation to provide adequate networks.

As evidenced by PPBP conduct or, more aptly, misconduct in response to certain provisions of the new PPBP/EPBP network adequacy rules, more work needs to be done by the Department to ensure that the networks being offered by both insurers and HMOs meet consumer expectations, as well as statutory obligations.

More specifically, the need for increased regulatory scrutiny of and enforcement over networks offered by insurers and HMOs is demonstrated by recent media reports concerning the ***overwhelming*** failure of PPBPs to submit annual network adequacy reports by the April 1, 2014 deadline. As detailed in a *Houston Chronicle* article on December 10, 2014:

> … reports for only 25 of the 140 preferred provider plans offered in Texas were submitted by an April 1 deadline. And after more than seven months in which regulators have not levied any sanctions, only three more [plans] have submitted reports.

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[1] *See, generally*, Preferred Provider Benefit Plan adopted rules (filed with the Secretary of State on May 19, 2011); published in the Texas Register on June 3, 2011 at 36 TexReg 3411 et seq; *available at*: http://texinfo.library.unt.edu/texasregister/pdf/2011/0603is.pdf

[2] House Bill 1772 (82nd Legislature, Regular Session); *available at*: http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/HB01772F.pdf#navpanes=0

[3] See 38 TexReg 827 et seq. Note that per 28 Tex. Admin. 3.3701, the subchapter applies to any preferred or exclusive provider benefit plan that is offered, delivered, or issued for delivery on or after 150 days from the effective date of the rules. However, the subchapter does not apply to an EPBP regulated under 28 Tex. Admin. Code Chapter 3, Subchapter KK (relating to Exclusive Provider Benefit Plan) written by an insurer under a contract with the Texas Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program, Medicaid, or with the Statewide Rural Health Care System.

> Without the reports, state officials have no way to tell if insurance plans being sold to millions of Texans include enough choice of health care providers for the prices that consumers are paying.[4]

In the same article, Department staff expressed concern that they are unable to determine whether plans have adequate networks. And, "Department spokesman, John Greely said the insurance companies deserve leeway because this was the first year in which the reports were required."[5]

Although TMA understands that this is the first year that PPBPs have been required to submit annual network adequacy reports, TMA notes that the annual network adequacy report is not a new regulatory concept. It was contained originally in the rules adopted by Commissioner Geeslin in May of 2011[6] (which were subsequently suspended by Commissioner Kitzman by Commissioner Bulletin prior to enforcement). And, despite repeated insurer efforts to remove the requirement from the adopted rules, it is important to note that it is a part of the current rules, which have been in effect since February 21, 2013. Thus, the plans have had more than ample time to bring themselves into compliance.

Yet, the PPBPs have overwhelmingly failed to provide the reports to TDI, which (rightly or wrongly) gives the appearance of: (1) a lack of desire for health plan transparency regarding the adequacy of their networks; (2) a lack of prioritization on network adequacy and regulatory compliance; or (3) some combination thereof. Whatever the intention of the plans in failing to comply with this basic network adequacy standard, the result is unacceptable to Texas' consumers who need TDI to be armed with sufficient information to assess network adequacy and who expect TDI to hold the plans accountable for falling short of their statutory obligations.

This clear PPBP noncompliance only underscores the need for strong TDI regulatory oversight of insurers and HMOs. As Blake Hutson, described by the *Houston Chronicle* as "a Texas-based health care expert for the national Consumer's Union advocacy group"[7] stated in the aforementioned article, "Network adequacy is one of the biggest problems that consumers face, so to the extent that these companies aren't complying with the law, we see that as a problem."[8]

If health plans are not inclined to prioritize network adequacy requirements, as is implied by plan failure to comply with the most basic network adequacy reporting requirement, then it becomes much more important for the Department to ***make*** the health plans prioritize network adequacy through strong regulatory and enforcement actions. Without being required to comply with clear, robust network adequacy standards, plans are not likely to voluntarily rise to meet consumer expectations. And, as demonstrated by the mass failure to comply with the annual network adequacy report filing requirement, even when insurers are required to comply with regulatory standards, they sometimes disregard the rules. Thus, now is the time for TDI to take a more aggressive stance in protecting consumers by actively enforcing the current PPBP network

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[4] Brian M. Rosenthal, Most insurance companies not complying with billing transparency law, Houston Chronicle, Dec. 10, 2014; *available at*: http://www.houstonchronicle.com/news/politics/texas/article/Most-insurance-companies-not-complying-with-5948898.php

[5] *Id*.

[6] See 36 TexReg 3497, June 3, 2011; available at: http://texinfo.library.unt.edu/texasregister/pdf/2011/0603is.pdf

[7] Brian M. Rosenthal, supra note 4.

[8] *Id*.

adequacy rules, as well as strengthening the rules it is currently revisiting (i.e., the HMO network adequacy rules).

With that being said, TMA understands the complexity involved in drafting regulations (especially those concerning network adequacy) and appreciates TDI's efforts in drafting this informal working draft HMO proposal. TMA also acknowledges that this informal draft is a first step by the Department in revisiting the HMO rules and is subject to further revision upon receipt of stakeholder comment. Thus, there is abundant time and room for improvement. TMA appreciates the opportunity to work with the Department to facilitate the Department's promulgation of more meaningful, consumer-friendly rules.

However, TMA feels compelled to express our initial disappointment that in an environment of: (1) heightened consumer dissatisfaction with the networks offered by insurers and HMOs and (2) demonstrated insurer disregard for compliance with basic elements of TDI's new PPBP/EPBP network adequacy standards, the Department has failed to use the informal working draft HMO rule proposal as a means of significantly strengthening the long-standing HMO network adequacy provisions and has, instead, even proposed taking some significant steps to ***loosen*** existing TDI regulation of HMO network adequacy.

TMA's primary concerns with the Department's informal draft proposal are as follows:

- The rule proposal works to reduce the value of HMO products available to consumers and to increase consumer out-of-pocket expenses by: (1) doubling the miles HMO consumers may be required to travel for coverage for primary care and general hospital care in rural areas; (2) proposing less rigorous standards under which an HMO may obtain an access plan (which effectively acts as a waiver that relieves HMOs from their obligation to comply with the core network adequacy requirements); and (3) creating a new framework under which the HMO's long-standing duty to hold the consumer harmless when a physician or provider is not reasonably available in-network may be lost if the consumer fails to use one of three out-of-network providers selected by the HMO.

- The rule proposal, at times, takes a one-size-fits all approach to network adequacy regulation by seemingly cutting and pasting some of the provisions from the PPBP/EPBP network adequacy rules into the HMO rules without necessarily tailoring them to fit the HMO framework (with a resulting potential for consumer harm in, for example, the proposed mileage provisions). As TMA has argued in the past, each of the three primary managed care products regulated by TDI (i.e., EPBPs, PPBPs and HMOs) has different features and each requires separate consideration from a regulatory perspective (with more stringent requirements imperative for closed-network products).

  While TMA strongly supports the inclusion of many of the consumer-friendly PPBP/EPBP provisions in the HMO rules (e.g., the annual network adequacy report, plan designation requirements, and other disclosure requirements), TMA urges the Department to take a considered approach in determining which network adequacy requirements should be applicable in all three products (with a focus on making uniform those provisions that protect consumers by requiring HMOs to fulfill their

responsibilities) and supplementing or tailoring those provisions as necessary for the specific product. Ease of insurer compliance with uniform network adequacy standards for all three products should not be the motivation for standardizing provisions that may work to the detriment of Texas' consumers (as appears to be the case in the Department's transplant of some of the PPBP/EPBP mileage and access plan provisions in the proposal).

- The rule proposal laudably attempts to incorporate some of the transparency and consumer protection provisions from the recently-adopted PPBP/EPBP network adequacy rules; however, the Department's proposal fails to inform consumers sufficiently so that they may appropriately avail themselves of those protections. If not amended, the Department's failure to require more prominent notice of the additional consumer protections, such as protection for consumers who detrimentally rely on inaccurate provider listings, will likely result in the newly proposed consumer protections existing largely in form with little substantive benefit to consumers; and

- In spite of recently demonstrated health plan disregard of the PPBP/EPBP network adequacy rules, the informal working draft HMO rule proposal reflects a philosophy of heightened reliance on the representations made by HMOs (e.g., in the access plan provisions and in the substantial decrease of preferred providers provision) with little vetting by TDI. The rule proposal does not reflect the clear need for the Department to take a more proactive regulatory and enforcement stance (including active monitoring of the plans), as is necessary to motivate HMO compliance with the rules.

Based upon the above concerns, TMA fears that, if the Department does not alter its current path, the Department's proposal will ultimately result in irreparable harm to Texas' consumers as, among other things, the value of the HMO products they have purchased will be reduced; their out-of-pocket expenses will be increased; and potentially deceptive HMO coverage will be allowed in the market for purchase by unsuspecting Texas consumers. This harm could easily be minimized, if not entirely avoided, if the Department were to proceed with a more robust regulatory/consumer protection stance in revising the rules (as set forth herein).

As the Department considers stakeholder comments on the informal working draft proposal provisions on HMO network adequacy, TMA respectfully requests that the Department focus on: (1) strengthening, rather than weakening, the existing network adequacy standards applicable to HMOs; (2) requiring compliance with the HMO network adequacy standards to be the rule (not the exception); and (3) reducing HMO reliance on alternatives to network adequacy by providing more up-front vetting of HMO networks and monitoring of HMO networks, while strengthening important back-end protections for consumers to rely upon in instances of HMO compliance failures.

With those principles in mind, TMA respectfully offers the following comments delineating its objections to and recommendations for specific sections of the HMO informal draft rule proposal on network adequacy.

II. Section 11.1607(h). Accessibility and Availability Requirements – Mileage Requirements

In Section 11.1607(h), TDI proposes a major modification to the existing mileage requirements for HMO network adequacy. Under current TDI regulations, subsection (h) states that "an HMO is required to provide an adequate network for its entire service area. All covered services areas must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) 30 miles for primary care and general hospital care; and
(2) 75 miles for specialty care, specialty hospitals, and single health care plan physicians or providers."

TDI now proposes modifying the mileage requirement for HMO network adequacy in subsection (h)(1) by ***doubling*** the miles a patient may be required to travel in rural areas to obtain primary care and general hospital care, while still considering the network to be "adequate." In other words, TDI proposes changing the network adequacy standard in subsection (h)(1) to 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care.

TMA is ***strongly opposed*** to the Department's proposal to expand the mileage requirements for rural access to primary care and general hospital care, as this is a significant ***weakening***, rather than strengthening, of the existing network adequacy standard applicable to HMOs with regard to the most basic care that every consumer would expect to be encompassed ***locally*** in-network as part of his or her HMO benefit.

If the Department were to move forward with this proposal (as currently drafted), no access plan would be required for an HMO that satisfies this new lax standard. Thus, in striking contrast to the current HMO regulations, no alternative measure for providing HMO consumers with coverage (and arguably, no application of the exception under Section 1271.055 of the Texas Insurance Code) would be required under the Department's proposal in instances in which HMO enrollees were ***unable*** to obtain in-network primary care or general hospital care within 30 miles in rural areas. Instead, under the Department's proposal, the HMO would have fully satisfied its regulatory duty if coverage were available within 60 miles in rural areas. This is a ***very significant*** reduction in the coverage benefits that must be provided to rural HMO enrollees when compared to TDI's current regulations.

As the Department is aware, ensuring in-network access to local providers is especially critical with a closed-network product (such as an HMO) that generally[9] offers ***no coverage*** out-of-network. Yet, the Department's proposal fails to provide this ***basic*** coverage for rural consumers. TMA is greatly concerned that the proposal would: (1) result in a significant reduction in the value of ***all*** HMO products currently offered to rural consumers in the market; and (2) shift more costs to rural consumers who would be required to pay in full for services that

[9] Note, however, the statutory exceptions applicable to emergency care and when medically necessary covered services are not available through network physicians or providers at Texas Insurance Code Sections 1271.155 and 1271.055, respectively.

are currently required to be covered by HMOs. TMA urges the Department to avoid this unjust result for Texas' rural consumers.

Based upon the Department's comments at its stakeholder meeting on December 12, 2014, TMA understands that the impetus for the proposed mileage change was a desire to align the HMO network adequacy mileage standard with the mileage standard that was recently adopted for PPBP and EPBP products. While TMA can appreciate the insurer desire to have one standard (especially one low standard) with which to comply across all products, TMA urges the Department to place consumer needs over ease of insurer compliance.

Furthermore, if the Department were to align the PPBP and EPBP network adequacy requirements, it is important to note that the HMO network adequacy mileage requirements ***predated*** the PPBP and EPBP standards by many years. Thus, any alignment should have gone in the other direction. In other words, the PPBPs and EPBPs should have been required to comply with the more stringent standard that has been applicable to HMOs for several years.

For all of the foregoing reasons (and with an emphasis on the consumer harm that may otherwise occur), TMA strongly cautions the Department not take an approach that may act as a race to the bottom from a regulatory perspective. Instead, the PPBP and EPBP mileage requirements should, at a minimum, be brought up to the existing HMO standard. Additionally, TMA once again recommends, as we did previously in the PPBP rules (and with even more urgency in a closed network HMO product), that the Department ***reduce*** the existing HMO mileage requirements to provide a more robust regulatory framework for consumers.

To that end, TMA recommends that, absent a compelling pro-consumer justification (with supporting data) for doing otherwise, TDI modify the existing mileage requirements so that HMO network adequacy is measured by distances of not greater than 15 miles in non-rural areas and 30 miles in rural areas for primary care and general hospital care. Further, for specialty care, specialty hospitals and single healthcare service plan physicians and providers, TMA recommends that the distance be reduced to 45 miles, rather than 75 miles.

III. Section 11.1607. Accessibility and Availability Requirements – Access Plan

Next, in new subsection (j) of Section 11.1607, the Department sets forth the requirements for the submission of an access plan by an HMO if the HMO fails to meet the network adequacy requirements of subsections (b) through (h) of the Section. The Department proposes deleting the existing access plan requirements in current subsection (j) and replacing those requirements with elements that track more closely the language for access plans in the PPBP/EPBP rules.

While TMA does not oppose the inclusion of many of the access plan components from the PPBP/EPBP rules into the HMO rules, TMA is concerned that the Department's HMO draft proposal intends for the access plan to function as an extended waiver of the application of the network adequacy requirements in subsection (b) through (h) without requiring a corresponding waiver approval process (such as one that is present in the PPBP/EPBP rules) for continued use of an access plan. In the PPBP/EPBP rules, the waiver process is a separate process whereby the insurer proves that it has good cause for departing from the network adequacy standards. An

access plan is then used as a method for demonstrating how the plan will provide alternative access to coverage ***if*** granted a waiver. Without a waiver in place, under the PPBP/EPBP rules, an access plan may only be used as a ***temporary*** stop-gap measure to provide alternative access to insureds when a plan is non-compliant. More specifically, see 28 TAC §3.3707(i), which states the following:

> (i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific service area, the insurer must establish a local market access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver pursuant to subsection (a) of this section requesting that the department approve the continued use of the local market access plan.

If, in fact, the Department intends for the access plan under subsection (j) to act as an extended waiver from the application of the network adequacy requirements, TMA contends that it is imperative that an explicit set of criteria to enable a waiver analysis and approval be present in the rules, in addition to any proposed access plan language.

More specifically, the Department must: (1) establish a rigorous process requiring that HMOs obtain waiver approvals from the Department for continued use of an access plan (as well as approvals of associated access plans); (2) specify required elements that must be included in the HMO's request for a waiver (as well as elements that are required to be present in the access plan); (3) set forth strenuous criteria that must be satisfied for the Department's approval of any waiver and associated access plan; and (4) establish a framework for ongoing TDI oversight and scrutiny of non-compliant plans. If the HMO is unable to satisfy the network adequacy standard and is unable to satisfy the criteria for approval of a waiver and approval of an access plan, the HMO should ***not*** be permitted to offer that product on the market (as the HMO would be offering a deficient product without good cause and/or without an adequate substitute method for providing the enrollee with promised access to coverage). To permit the offering of such a product would be tantamount to TDI sanctioning deceptive products on the market. And, any HMO that fails to meet the network adequacy provisions without a waiver and/or an access plan in place (and/or without abiding by the terms of the access plan) should be subject to robust enforcement actions and sanctions.

TMA also contends that it is imperative that the Department severely limit the circumstances in which a waiver and use of an access plan are permitted for HMOs. ***Use of a waiver and access plan should be the rare exception, not the rule.*** Furthermore, an access plan should ***not*** be the basis for continued operation, absent impossibility with complying with the network adequacy standards due to no fault of the HMO. In a closed-network product, such as an HMO, the value of the product is only as good as the underlying network. Thus, it is important for the network adequacy requirements to be ultra-robust and for the Department to hold HMOs to those standards. A consumer should not be placed in a position in which he thinks he purchased a

network benefit only to subsequently learn that all he actually purchased was a limited alternative access benefit (as set forth in the access plan).

TMA is concerned that, as currently proposed, the Department's access language would permit any HMO to avoid the application of the network adequacy requirements for ***any*** reason whatsoever that is deemed suitable by TDI or that is simply approved by default after the 30 day automatic approval period expires. This is true, because the language proposed in (j) merely requires, among other elements, that an HMO that is unable to meet the requirements of subsections (b) – (h) file an access plan for approval and in the access plan specify the reason or reasons the network does not meet the adequacy requirements. The proposed access plan rule provisions do ***not*** set forth any objective criteria that limit or otherwise specify the acceptable reasons for failure to comply with the network adequacy requirements that would form the basis of the Department's approval of an access plan.

In our opinion, the Department's access plan proposal is a step back from the existing HMO rules in that respect, because the current rules provide only three permissible grounds that form the basis for filing an access plan and obtaining approval of an access plan, namely, if: (1) any covered health care service or a participating physician and provider is not available to an enrollee within the mileage radii specified in [the rules] because physicians and providers are not located within such mileage radii; (2) the HMO is unable to obtain contracts after good faith attempts; or (3) physicians or providers meeting the meeting minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii. TMA notes that these existing three exceptions are similar to the waiver standards in the PPBP/EPBP rules and, at least, attempt to place some parameters on acceptable reasons for HMO failure to satisfy the network adequacy standards.

The criteria for approval of a waiver and continued use of an access plan should be limited to circumstances that are largely beyond the HMO's control. The three current TDI exceptions for HMOs (referenced above) attempt to implement this standard. However, none of those guardrails exist in TDI's proposed re-write of subsection (j). This lack of clear criteria for eligibility for an access plan/waiver is even more troubling when read in conjunction with the Department's language in proposed Section 11.301, which provides that the access plan will be automatically deemed approved if the Department does not deny it within 30 days (or the one-time extension period of 30 days). If the default position is going to be approval of the access plan, then the gatekeeping function of limiting what is eligible for approval becomes even more critical. Without the gatekeeping function, TMA fears that every HMO will be able to circumvent the core network adequacy requirements through use of an access plan; thereby rendering the network adequacy standards meaningless. Thus, TMA urges the TDI to restrict the bases for the granting of the waiver/access plan and carefully consider its re-write of the access plan provisions.

Further, given all of the above concerns, TMA contends that the access plan provisions of the proposed TDI rules may potentially serve as the determinative factor of whether the HMO network adequacy rules exist only in form or actually have some true function. For this reason, TMA reserves further comment on the access plan provisions and respectfully requests a meeting with Department staff to continue a dialogue on this subsection (as well as the remainder of the

proposed rule provisions on network adequacy) in order to gain a better understanding of the Department's intended use of the access plan in the overall regulatory framework of the HMO rules.

IV. Section 11.1610. Annual Network Adequacy Report

Next, the Department proposes a new Section 11.1610, which would require each HMO to file an annual network adequacy report with the Department on or before August 1 of each year and prior to marketing any plan in a new service area. The provisions of this proposed Section largely track the annual network adequacy report requirements present in the current PPBP/EPBP network adequacy rules (with some tailoring to the HMO product). Basic elements required to be included in the report include the trade name of each HMO plan in which enrollees currently participate, the applicable service area of each plan, and whether the HMO service delivery network supporting each plans meets the requirements in Section 11.1607 of the title. Additionally, information regarding claims for out-of-network benefits and complaints received by the HMO relating to network adequacy must be disclosed in the report.

A. The need for an annual network adequacy report for HMOs

TMA ***strongly supports*** the Department's inclusion of a requirement for HMOs to file an annual network adequacy report. As TMA has stated previously in the PPBP/EPBP context, the annual network adequacy report can be described aptly as the "heart" of the regulatory framework created by TDI for network adequacy purposes, as it enables the Department to obtain an overview of the status of the networks being offered to consumers.

All of the basic information included in proposed Section 11.1607 is vital to the Department's: (1) monitoring of an HMO's compliance with established network adequacy requirements and (2) future determinations regarding whether the basic network adequacy requirements (e.g., mileage requirements) are sufficient.[10] It naturally follows that inclusion of this proposed provision is critical to prevent HMOs from keeping the true condition of their networks shrouded from the scrutiny of their customers and the Department.

TMA commends the Department for recognizing the vital importance of this provision and for proposing the inclusion of this basic transparency requirement in the HMO network adequacy regulatory framework.

In previously adopting the annual network adequacy report in the PPBP rules, the Department, itself, made the following statement regarding the rationale for adoption of the annual network adequacy report requirement (as published in the Texas Register):

> New §3.3709 establishes annual network adequacy report and access plan requirements in order to facilitate the Department's monitoring of compliance

[10] See 36 TexReg 3457 and TDI's statement in the PPBP context that "Nevertheless, the Department intends to monitor implementation of this rule in order to determine whether the mileage requirements are appropriate in practice. Specifically, the Department will monitor the data received pursuant to new §3.3709(c), which requires insurers to file annual network adequacy reports with the Department, including information about the number of complaints by insureds relating to the availability of preferred providers."

> with network adequacy standards and to minimize the impact to insureds resulting from an insurer's use of an inadequate network.[11]

The Department continued by stating the following:

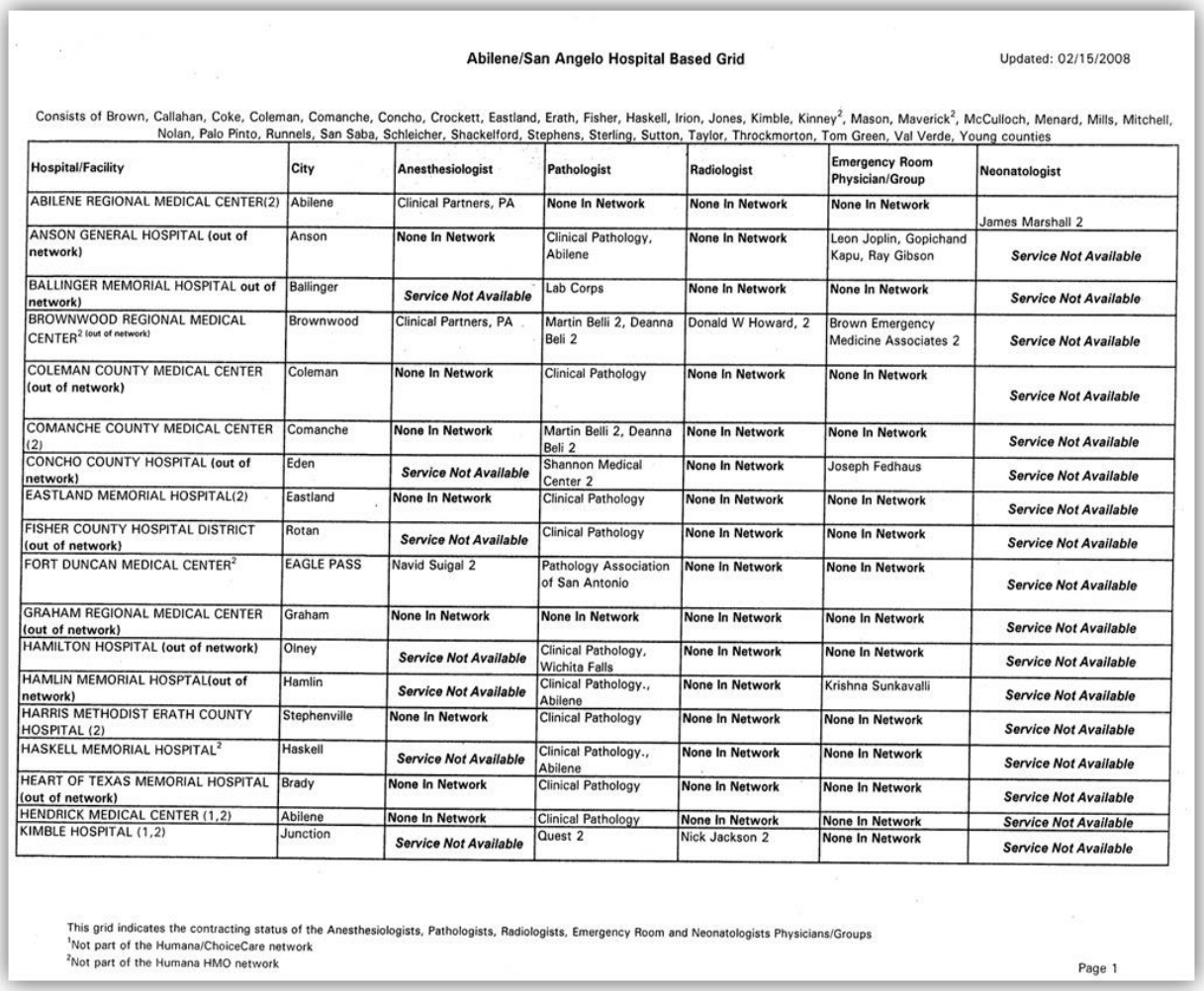
> Section 3.3709(c) is ***necessary*** because data collected by the Department indicates that insurers do not closely monitor some important network adequacy indicators. …
>
> The information required to be reported under §3.3709 will encourage insurers to more closely monitor these important network adequacy indicators. In conjunction with TDI complaint data, the information will also facilitate the Department's oversight of compliance with network adequacy requirements on an ongoing basis in order to determine if additional examination of particular insurers is necessary.[12]

All of the same statements made by the Department (above) with regard to the importance and benefit of an annual report to regulating networks offered by insurers in the PPBP context should apply with equal (if not greater) force in the closed-network context of HMOs. Thus, it is imperative that the Department adopt an HMO annual network adequacy reporting requirement.

To further illustrate the need for regular network adequacy reporting, TMA has attached a 2008 document submitted to the TDI Network Adequacy Committee by Humana. This grid (for Humana's products offered in San Angelo) indicates that the company had serious network issues that were, until that time, not generally known to the public (see grid

[11] 36 TexReg 3414
[12] *Id*. (Emphasis added).

below):



Abilene/San Angelo Hospital Based Grid Updated: 02/15/2008

Consists of Brown, Callahan, Coke, Coleman, Comanche, Concho, Crockett, Eastland, Erath, Fisher, Haskell, Irion, Jones, Kimble, Kinney[2], Mason, Maverick[2], McCulloch, Menard, Mills, Mitchell, Nolan, Palo Pinto, Runnels, San Saba, Schleicher, Shackelford, Stephens, Sterling, Sutton, Taylor, Throckmorton, Tom Green, Val Verde, Young counties

Hospital/Facility	City	Anesthesiologist	Pathologist	Radiologist	Emergency Room Physician/Group	Neonatologist
ABILENE REGIONAL MEDICAL CENTER(2)	Abilene	Clinical Partners, PA	None In Network	None In Network	None In Network	James Marshall 2
ANSON GENERAL HOSPITAL (out of network)	Anson	None In Network	Clinical Pathology, Abilene	None In Network	Leon Joplin, Gopichand Kapu, Ray Gibson	Service Not Available
BALLINGER MEMORIAL HOSPITAL out of network)	Ballinger	Service Not Available	Lab Corps	None In Network	None In Network	Service Not Available
BROWNWOOD REGIONAL MEDICAL CENTER[2 (out of network)]	Brownwood	Clinical Partners, PA	Martin Belli 2, Deanna Beli 2	Donald W Howard, 2	Brown Emergency Medicine Associates 2	Service Not Available
COLEMAN COUNTY MEDICAL CENTER (out of network)	Coleman	None In Network	Clinical Pathology	None In Network	None In Network	Service Not Available
COMANCHE COUNTY MEDICAL CENTER (2)	Comanche	None In Network	Martin Belli 2, Deanna Beli 2	None In Network	None In Network	Service Not Available
CONCHO COUNTY HOSPITAL (out of network)	Eden	Service Not Available	Shannon Medical Center 2	None In Network	Joseph Fedhaus	Service Not Available
EASTLAND MEMORIAL HOSPITAL(2)	Eastland	None In Network	Clinical Pathology	None In Network	None In Network	Service Not Available
FISHER COUNTY HOSPITAL DISTRICT (out of network)	Rotan	Service Not Available	Clinical Pathology	None In Network	None In Network	Service Not Available
FORT DUNCAN MEDICAL CENTER[2]	EAGLE PASS	Navid Suigal 2	Pathology Association of San Antonio	None In Network	None In Network	Service Not Available
GRAHAM REGIONAL MEDICAL CENTER (out of network)	Graham	None In Network	None In Network	None In Network	None In Network	Service Not Available
HAMILTON HOSPITAL (out of network)	Olney	Service Not Available	Clinical Pathology, Wichita Falls	None In Network	None In Network	Service Not Available
HAMLIN MEMORIAL HOSPTAL(out of network)	Hamlin	Service Not Available	Clinical Pathology., Abilene	None In Network	Krishna Sunkavalli	Service Not Available
HARRIS METHODIST ERATH COUNTY HOSPITAL (2)	Stephenville	None In Network	Clinical Pathology	None In Network	None In Network	Service Not Available
HASKELL MEMORIAL HOSPITAL[2]	Haskell	Service Not Available	Clinical Pathology., Abilene	None In Network	None In Network	Service Not Available
HEART OF TEXAS MEMORIAL HOSPITAL (out of network)	Brady	None In Network	Clinical Pathology	None In Network	None In Network	Service Not Available
HENDRICK MEDICAL CENTER (1,2)	Abilene	None In Network	Clinical Pathology	None In Network	None In Network	Service Not Available
KIMBLE HOSPITAL (1,2)	Junction	Service Not Available	Quest 2	Nick Jackson 2	None In Network	Service Not Available

This grid indicates the contracting status of the Anesthesiologists, Pathologists, Radiologists, Emergency Room and Neonatologists Physicians/Groups
[1]Not part of the Humana/ChoiceCare network
[2]Not part of the Humana HMO network

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To prevent serious network gaps of the type previously identified by the Department's Network Adequacy Committee (such as those above) and to ensure close monitoring of HMO networks by both HMOs and the Department, TMA strongly supports the inclusion of proposed Section 11.1610 with the recommended modifications suggested below.

B. Recommended modifications to Section 11.1607

In order to strengthen the network adequacy annual reporting requirements, TMA recommends the following modifications to proposed Section 11.1607:

First, in subsection (c), which begins on line 3736, TMA recommends that all the itemized demographic information listed in the subdivisions of subsection (c) be reported on the basis of geographic regions within the applicable service area. Providing more specificity in the reporting requirement will aid the Department in assessing: (1) the local impact of the Department's network adequacy requirements and (2) the HMO's ability (or inability) to satisfy those requirements.

Next, in subsection (c)(4), TMA recommends that the Department require HMOs to include as part of the report, the number of complaints made by network ***physicians*** (as well as providers) relating to the inability to refer enrollees to network physicians or providers due to the unavailability of network physicians or providers. As currently drafted, (c)(4) only requires an accounting of the complaints made by network ***providers*** (which does not include physicians). TMA believes this was merely an oversight and respectfully requests that it be corrected.

Next, TMA recommends that the Department add a new (c)(9) to require the annual network adequacy report to include the number of complaints made by ***physicians and providers*** relating to the accuracy of network provider listings. Currently, proposed (c)(8) only requires HMOs to disclose the number of complaints made by ***enrollees*** relating to the accuracy of network provider listings. Physicians and providers will be in a better position than enrollees to assess the accuracy of their own listings; thus, it is important for an HMO to specify the number of complaints received from physicians and providers (in addition to those received from enrollees).

Next, TMA recommends that the Department add a new catch-all (c)(10), to require HMOs to include the number of complaints relating to any other network adequacy requirement under the subtitle that is not already encompassed by subdivisions (c)(4) through (c)(9).

Next, in the second proposed subsection (c), which begins on line 3751, the Department states that the annual network adequacy report must be submitted electronically in a format and by a method acceptable to the Department. The proposal goes on to state that unless and until a standardized form and method for submitting the information is made available by the Department, acceptable formats include Microsoft Word and Excel documents.

While TMA understands the desire to provide HMOs with some flexibility in the submission of annual reports, TMA urges the Department to promptly develop a standard form and format to be used by all HMOs in submitting the required annual report. Due to the important public policy discussion that is ongoing regarding network adequacy, it is important that the Department create a system that facilitates ease of retrieval and analysis of the information submitted by HMOs in the annual network adequacy reports in order to comply with requests for that information when made by consumers, health care providers, and the Texas Legislature. In particular, it is important that the information required to be disclosed under subsection (c), beginning on line 3736, be available separately from the remainder of the report in an easy-to-read table format. To that end, TMA recommends that the Department promptly adopt a standard Excel spreadsheet form to be used by all HMOs in submitting the information required under subsection (c).

Finally in subsection (d), TDI largely tracks the language from the PPBP/EPBP network adequacy rules, by authorizing the commissioner to issue cease and desist orders if the commissioner determines, after notice and opportunity for hearing, that the HMO's network and any access plan supporting the network are inadequate. While TMA clearly supports TDI's authority to order an HMO that is failing to meet regulatory standards to reduce its service area, cease marketing in parts of the state, and cease marketing entirely and withdrawal from the HMO market, TMA is concerned that the language in proposed subsection (d) only permits the Department to issue a cease and desist order under subsection (d) if both the network and any

access plan supporting the network are considered inadequate. If the Department moves forward with this language, then TMA, once again, reiterates the importance of only sparingly allowing the use of access plans. Additionally, if an HMO fails to comply with the terms of its access plan, it should also be subject to all available sanctions.

V. Proposed Section 11.1611. Out-of-Network Claims; Non-Network Providers

Next, in proposed Section 11.1611, the Department, for the first time, proposes to expressly set forth in rule the requirements for HMO payment of certain out-of-network services. While TMA does not oppose, in theory, the Department's desire to clarify requirements applicable to HMOs for proper payment of out-of-network claims, TMA is concerned that the framework offered by the Department in the informal working draft rule fundamentally alters long-standing Department interpretations of the HMO out-of-network payment provisions and, in some instances, also fails to reflect the statutory directives applicable to HMOs.

A. Proposed Section 11.1611(a)

1. TMA Opposes Proposed Section 11.1611(a) as currently drafted

First, in proposed Section 11.1611(a), the Department proposes adopting the following language regarding payment for out-of-network services provided by a "non-network facility-based physician":

> (a) When services are rendered to an enrollee by a non-network facility-based physician and there is a difference between the usual and customary rate and the billed charge, the HMO must provide notice to the enrollee:
> (1) That informs the enrollee that the non-network facility-based physician may balance-bill the enrollee; and
> (2) That informs the enrollee of the procedures for contacting the HMO on receipt of a bill for covered services from the non-network facility-based physician.

TMA ***opposes*** the language in proposed Section 11.1611(a), ***as currently drafted***, as it appears to extend HMO coverage beyond that which is authorized under Texas law. As currently drafted, the service described in proposed Section 11.1611(a), which is a non-emergency out-of-network service provided by a "non-network facility-based physician" at a non-network facility, should not be considered an HMO covered service ***at all*** under existing Texas law.

This is true, because, as the Department is aware (and as is accurately reflected in the Department's proposed notice to be provided under new Section 11.1611 of these informal working draft rules), an HMO plan is a closed network product that ***generally*** provides ***no benefits*** for services received by enrollees from out-of-network providers. As stated in the Department's "Report of the Health Network Adequacy Advisory Committee,"

> 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.[13]

The non-network scenario presented by proposed subsection (a) falls within the general rule (of no coverage out-of-network), rather than one of the two exceptions described by the Report and set forth in Sections 1271.055 and 1271.155 of the Texas Insurance Code.

Proposed subsection (a) merely describes an HMO enrollee who chooses to go outside of his or her HMO network by selecting a non-network facility and a non-network physician or provider. Thus, in the scenario described in subsection (a), the HMO should not be required to pay ***anything*** (much less the usual and customary rate described in proposed (a)(1)) for the service.

Furthermore, the bill that is provided to the HMO enrollee in the circumstance described in subsection (a) is not properly termed a "balance bill." As clearly stated in the Report of the Health Network Advisory Committee, a "balance bill" results when "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…."[14] In such cases "the patient may receive a bill for the balance of charges not paid by the health plan."[15]

In the circumstance described in proposed subsection (a), the patient does not receive a bill for the "balance" of charges not paid by the health plan (as, once again, the health plan is not obligated to pay ***anything***). Rather, the patient merely receives a bill for which he or she is fully responsible.

TMA opposes the current language of subsection (a) as it appears to create an HMO benefit that does not exist under current Texas law.

2. Recommended Modifications to Proposed Section 11.1611(a)

Given that the language in proposed Section 11.1611(a), ***as currently drafted***, does not appear to be consistent with either: (1) the Department's prior statements regarding the general rule for no out-of-network coverage for HMO services; or (2) the Department's most recent statement in the notice of proposed Section 11.1611 regarding the general rule of no out-of-network coverage for HMO services, TMA believes that the Department may have inadvertently omitted language that it intended to include in proposed Section 11.1611(a).

In particular, based upon the Department's past official statements regarding out-of-network claims for services provided by out-of-network providers at in-network facilities, TMA believes that the Department may have omitted language that was intended to limit proposed subsection (a) to out-of-network services received at in-network facilities.

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[13] Texas Department of Insurance, Report of the Health Network Adequacy Advisory Committee, Senate Bill 1731, Section 11, Eightieth Legislature, Regular Session 2007, January 2009 at 9; available at: https://www.tdi.state.**tx**.us/**reports**/life/documents/hlth**network**09.doc

[14] *Id* at 8.

[15] *Id*.

More specifically, in the Department's Biennial Report to the 80th Legislature, the Department stated the following with regard to the Department's out-of-network referral exception to the general rule regarding no coverage for out-of-network HMO services:

> While Texas law contains a number of requirements promoting adequate HMO networks, networks may be inadequate for a number of reasons, including the inability of HMOs and providers to agree to contractual terms, usually involving payment rates. 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 then 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.
>
> Increasingly, referral to non-network providers is occurring after services have been rendered – a circumstance that may result in balance billing. This type of situation most often occurs with hospital-based providers, such as radiologists, anesthesiologists, pathologists, emergency room physicians and neonatologists. It occurs because an enrollee may choose a network hospital and surgeon, but may receive ancillary services from non-network providers while hospitalized.
>
> 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 have to pay an amount other than a copayment or deductible. 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.***[16]

In order to implement the Department's long-standing interpretation regarding HMO enrollee receipt of covered services in a network facility provided by a non-network provider (as expressly stated by the Department in its Biennial Report to the 80th Legislature above), TMA recommends the Department modify subsection (a) to read as follows:

(a) <u>When services are rendered to an enrollee by a non-network facility-based physician in a network facility, the HMO must fully reimburse the non-network facility-based physician at the usual and customary rate or at an agreed rate.</u>

It is important to note that TMA's recommended language for subsection (f), which is located in Section V. F. of this comment letter, also takes into account the Department's later statement in the same Biennial Report in which the Department expresses concern that HMO enrollees do not

[16] See pp. 10 – 11 of the Biennial Report of the Texas Department of Insurance to the 80th Legislature, December 2006, Mike Geeslin, Commissioner of Insurance; *available at*: http://www.tdi.texas.gov/reports/documents/finalbie07.pdf (emphasis added)

know how to address a balance bill upon receipt after being provided with non-network services at an in-network facility. More specifically, the Department previously stated as follows:

> Despite the legal protections, the current situation sometimes results in HMO enrollees paying more than anticipated or required because they are billed beyond their deductibles and copays for out-of network referrals. An enrollee who receives a balance bill should simply forward the bill to the HMO; however, most enrollees do not know to do so… [17]

TMA believes that the language we have offered (above) for subsection (a) in conjunction with language that we have recommended for subsection (f) (below in Section V. F. of this comment letter) will address this consumer concern and ensure that HMO enrollees are more fully apprised of both their obligations and the HMO's obligations in the event of receipt of out-of-network services at an in-network facility. Thus, TMA recommends that the Department consider this language in lieu of its current proposal.

B. Proposed Section 11.1611(b)

Next, in proposed Section 11.1611(b), the Department proposes the following language:

> (b) In circumstances where an enrollee cannot reasonably reach a network provider, including circumstances where an enrollee is not given a choice between network and non-network providers when receiving care at a network facility, the HMO must fully reimburse a non-network provider for emergency care services at the usual and customary rate as described in subsection (g) of this section or at an agreed rate until the enrollee can reasonably be expected to transfer to a network provider.

The language in proposed subsection (b) appears to be attempting to incorporate into rule the HMO's statutory responsibilities as related to payment of out-of-network emergency care. TMA both strongly supports and opposes portions of this draft language as set forth below.

First, it is important to note that under Section 1271.155 of the Insurance Code, an HMO is required to "pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate."

TDI has long interpreted this statutory provision to require an HMO to "fully" pay the out-of-network physician or provider. Thus, TMA ***strongly supports*** the Department's inclusion of the word "fully" into its working draft language (which clearly articulates TDI's long-standing desk rule). More specifically, in TDI's Biennial Report to the 80th Legislature, the Department stated as follows:

> The HMO Act 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.

[17] *Id*. at 11.

> Nonetheless, the Department interprets the statute to require that an HMO enrollee not be responsible for payment of a balance bill. While different, the critical statutory similarity is that the prepaid nature of HMO coverage and the concept of pooling of risk requires that an HMO must hold harmless (except for scheduled expenses) its enrollees obtaining emergency care services. Any other interpretation could discourage HMO enrollee access to emergency care out-of-network, as enrollees fearful of financial harm might postpone necessary emergency care until they can return to their service area and network.[18]

While TMA strongly supports inclusion of the word "fully" into the emergency care reimbursement provision, TMA is concerned about other additions to proposed subsection (b) that are, ***for the first time***, added into the emergency out-of-network services language.

Specifically, TMA is concerned that the Department appears to be conflating in subsection (b) ***two separate statutory standards*** that exist for: (1) ***HMO*** payment for out-of-network emergency care (under Insurance Code Section 1271.155) and (2) ***PPBP*** payment for out-of-network emergency care (under Insurance Code Section 1301.155), in a manner that severely weakens the statutory protection provided for out-of-network emergency care services received by HMO enrollees.

The statutory requirement for HMOs to provide payment for emergency care services under Insurance Code Section 1271.155 (as discussed above and as described in the Department's Biennial Report) does ***not*** have any qualifying language. In other words, it does ***not,*** in striking contrast to the language in proposed subsection (b), limit its application to: (1) circumstances where an enrollee cannot reasonably reach a network provider or (2) the receipt of emergency care services until the enrollee can be reasonably expected to transfer to a network physician. Rather, only Insurance Code Section 1301.155 (which applies to PPBPs, ***not HMOs***) contains this qualifying language.

By adding the qualifying language that is inapplicable to HMOs as specifically set forth under Texas statutes, the Department is limiting the ability of the enrollees to receive their statutorily-authorized out-of-network emergency benefit in contravention of Insurance Code Section 1271.155. Thus, TMA ***strongly opposes*** inclusion of the aforementioned qualifying language that is proposed in both the introductory clause to subsection (b), as well as the final phrase in subsection (b). TMA urges the Department to strike this language.

Next, TMA ***strongly recommends*** that the Department include "physicians" (in addition to "providers") in the language in proposed subsection (b) that requires "the HMO [to] fully reimburse a non-network provider for emergency care services at the usual and customary rate … or at an agreed rate…"

Since the TDI proposed rules do not have a definition of "non-network provider" or "provider," one must (under Section 11.2 of the proposed rules) give the word "provider" the same meaning it has when defined in one of the listed Insurance Code Chapters. Under Insurance Code Section 843.002(24)(A), a "provider" is defined as "a person, ***other than a physician***, who is licensed or

[18] *Id.*

otherwise authorized to provide a health care service in this state…"(emphasis added). Thus, applying the provision in proposed subsection (b) to providers is insufficient to encompass physicians. TMA assumes that the omission of a "physician" in this language is merely an oversight, as other subsections in proposed Section 11.1611 refer to both non-network providers and non-network physicians. However, it is important for TDI to ensure that the language of the rule reflects its intent and the full applicability required by the underlying statute.

Finally, TMA also ***strongly recommends*** that the Department strike the qualifying language "as described in subsection (g)" that is contained within the requirement for an HMO to fully reimburse a non-network physician or provider for emergency care services at the usual and customary rate "as described in subsection (g)" or at an agreed rate. TMA is concerned that if the Department retains the "as described in subsection (g)" language, HMOs may ***inappropriately*** believe that they may discharge their obligation to "fully" reimburse the non-network physician or provider simply by using the methodology described in subsection (g).

Taking into account all of TMA's above recommendations, TMA strongly recommends that the Department modify its proposed language in subsection (b) as follows:

> (b)~~[In circumstances where an enrollee cannot reasonably reach a network provider, including circumstances where an enrollee is not given a choice between network and non-network providers when receiving care at a network facility, the]~~ An HMO must fully reimburse a non-network physician or provider for emergency care services at the usual and customary rate [~~as described in subsection (g) of this section~~] or at an agreed rate [~~until the enrollee can reasonably be expected to transfer to a network provider~~].

C. Proposed Section 11.1611(c)

Next in proposed Section 11.1611(c), the Department attempts to set forth the statutory exception found in Insurance Code Section 1271.055 regarding HMO coverage when medically necessary covered services are not available through network physicians or providers. Although TMA generally supports the Department's effort to repeat the statutory requirement in the regulation, TMA offers the following modifications to more closely track the statutory language of Insurance Code Section 1271.055:

(c) If medically necessary covered services, other than emergency care, are not available through a network physician or provider, the HMO, on the request of a [~~contracted~~] network physician or provider and within a reasonable period, [~~the HMO~~] must:

(1) Allow [~~Approve~~] a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(2) Before denying a request for a referral to a non-network or provider, provide [~~Provide~~] for a review conducted by a specialist of the same or similar type of specialty as the physician or [~~by a health care physician or provider with expertise in the same specialty as or a specialty similar to the type of health care~~] provider to

whom referral is requested under paragraph (1) of this subsection before the HMO may deny the referral; and

(3) Fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

It is important to note that in the recommended language above, TMA has added the statutory reimbursement standard that is located in Insurance Code Section 1271.055. Since the Department re-stated the reimbursement standard for out-of-network emergency care in subsection (b), TMA thought it was important to also re-state in subsection (c) the standard for reimbursement for out-of-network referrals in a situation in which a provider is not available. Re-stating the statutory standards in this fashion should aid in HMO compliance, since all the applicable standards will be clearly expressed in one Section of the HMO rules.

D. Proposed Section 11.1611(d)

Next, in proposed Section 11.1611(d), the Department proposes establishing a framework whereby the HMO may facilitate a referral to a non-network physician or provider when medically necessary covered services, excluding emergency care, are not available through a network physician or provider and an enrollee has received the referral from a network physician or provider.

In response to this proposal, TMA first notes that we do not oppose, ***in theory***, the Department permitting an HMO to facilitate referrals, provided that the "facilitation" is just that—a facilitation—without any associated punitive measures authorized for an enrollee's (or the requesting physician or provider's) failure to select one of the physicians or providers "facilitated" by the HMO. Unfortunately, this is not the framework the Department has developed. Thus, TMA ***strongly opposes*** the language in subsection (d) in its entirety, as currently drafted.

More specifically, TMA is concerned that subdivisions (1) through (3) of subsection (d) establish an HMO referral facilitation scheme that essentially functions as an ad-hoc network of three non-contracted physicians or providers that the HMO enrollee is required to use in order to obtain the out-of-network benefits that are ***required*** under Insurance Code Section 1271.055 (i.e., ***"fully"*** reimbursing the out-of-network physician or provider at the usual and customary or agreed to rate).

Under the current language in proposed subdivision (d)(3), if the HMO enrollee fails to use one of the three physicians or providers in the ad-hoc network, he or she is penalized by having the HMO relieved of its statutorily-mandated duty to hold the enrollee harmless (i.e., no longer requiring the HMO to "fully" reimburse the out-of-network provider). Presumably, the enrollee would then be responsible for paying any balance bill for services performed by the out-of-network provider. This ***punitive measure*** is not an acceptable result for Texas' HMO enrollees and makes little sense from either a legal or public policy standpoint. Thus, TMA opposes this framework on both legal and public policy grounds as set forth in more detail below.

1. **TMA opposes Proposed Section 11.1611(d), as currently drafted, because it contravenes Section 1271.055 of the Texas Insurance Code.**

First, it is important to note that under Section 1271.055 of the Texas Insurance Code, if medically necessary covered services are not available through network physicians or providers, the HMO, on the request of the network physician or provider and within a reasonable period of time, is ***required to***:

(1) Allow referral to a non-network physician or provider; and
(2) ***Fully*** reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate. (Note that the Department has long interpreted the Legislature's use of the word "fully" as imposing a duty on the HMO to hold the enrollee harmless.)

The ***only*** statutorily-authorized exception to this requirement is if the HMO denies a request for a referral to a non-network physician or provider after a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested.

There is ***no exception*** under the statute for situations in which the insurer recommends a list of three out-of-network providers for the performance of the necessary services and the enrollee (and his or her requesting physician or provider) declines to use one of those listed providers.

Yet, the Department appears to be proposing the creation of a new partial ***statutory*** exception via rulemaking. Under proposed subsection (d)(3) of the rules, if the physician or provider who requests the referral selects, with the agreement of the enrollee, a non-network physician or provider that is not included on the list provided by the HMO, then the HMO is still required to pay the non-network physician at the usual and customary or an agreed rate (i.e., part of the HMO's duty under Insurance Code Section 1271.055(b)(2)); however, the HMO is ***relieved*** of its statutory obligation to hold the enrollee harmless (i.e., the other part of the HMO's duty under Insurance Code Section 1271.055(b)(2)).

In other words, the Department is holding the HMO to its statutory obligation to allow referrals to a non-network physician or provider under Insurance Code Section 1271.055)(b)(1), but is only ***partially*** holding the HMO to its responsibility under Insurance Code Section 1271.055(b)(2) to "fully" reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

The Department is essentially unilaterally striking the word "fully" from the statutory reimbursement requirement found in Insurance Code Section 1271.055(b)(2) in those scenarios in which an enrollee chooses an out-of-network provider other than one of the three in the HMO's ad hoc list. It is unclear to TMA how the Department has authority to take such a step via rulemaking. If the Legislature had intended for there to be more exceptions to Section 1271.055's out-of-network services reimbursement requirement, it would have created one.

Thus, TMA opposes the Department's proposal of subsection (d), as currently drafted, because it appears to exceed the underlying statutory authority to which the Department is bound and does

so to the detriment of HMO enrollees (by making them liable for balance bills for which the HMO, rather than the enrollee, would otherwise be responsible for paying).

2. **TMA opposes Proposed Section 11.1611(d), as currently drafted, based upon public policy considerations.**

Additionally, TMA opposes proposed Section 11.1611(d), as currently drafted, for public policy reasons. TMA is concerned that the Department's language in proposed Section 11.1611(d)(3), which releases the HMO from its statutory duty to hold the enrollee harmless will: (1) reward bad behavior on the part of HMOs and (2) act as a disincentive for HMOs to create an adequate network upfront.

It is important to note that the out-of-network coverage required under Section 1271.055 of the Insurance Code is ***only*** required in situations in which medical necessary covered services are ***not available*** through network physicians or providers. Thus, this provision comes into play when the HMO has ***failed*** to provide an adequate network. The statutory provision is designed as a means to make the enrollee whole (i.e., have the HMO hold the enrollee harmless) so that the enrollee does not bear the burden of paying unanticipated expenses due to the HMO's failure to meet its statutory and regulatory obligations to provide a sufficient network.

The Department's proposal in subsection (d) ***weakens*** this statutory protection by partially relieving the HMO of this duty if the enrollee does not choose one of the three non-network physicians cobbled together by the HMO at the time of the enrollee's referral (in effect an ad hoc network of out-of-network providers). This smacks of unfairness to the consumer who was legally entitled to an adequate network and is now required to bear the burden of the HMO's failure in order to receive required treatment (and is subjected to what is effectively a micro network of three providers at the time that he needs care). The burden for the HMO's compliance failure should be the HMO's and the HMO's alone, as it chose to market and collect premiums for a deficient network. The enrollee should not be left holding the bill, literally.

Additionally, it should be noted that it may be entirely rational for the enrollee and the enrollee's requesting physician to choose someone other than the three listed physicians or providers "facilitated" by the HMO in such a scenario. This is true, because the proposed regulatory standard for the HMO to select the ad hoc network of three providers is fairly low. All that is necessary under proposed subsection (d)(1) is that the three physicians or providers have "expertise in the necessary specialty … [and are] reasonably available considering the medical condition and location of the enrollee."

It is unclear: (1) what the standard of "reasonably available" entails or (2) what level of "expertise" is required. For example, does the "reasonably available" standard require the enrollee to travel beyond the mileage radii required for an adequate network? And, what if the HMO's judgment of the "expertise" of the "facilitated" providers is not aligned with what the physician who is requesting the referral thinks, in his or her medical judgment, is sufficient for treating the patient's condition? Under both of those circumstances, it would be entirely rational for the requesting physician and enrollee to decline using the HMO-facilitated providers and search for another out-of-network physician. The enrollee should not be penalized for making

this rational decision, especially when the HMO's failure to provide an adequate network put the enrollee in the position of seeking a referral out-of-network in the first place.

It is difficult to believe that the Department would have construed a micro network of only three ad hoc providers to have been sufficient ***upfront*** in analyzing network adequacy standards. Why the Department would seek to bind an HMO enrollee to an ad-hoc micro network of three providers at the ***back end*** is unclear from a public policy standpoint.

Next, TMA also opposes subsection (d)(3) as currently drafted, because it will likely act as a disincentive for HMOs to provide adequate networks upfront. If an HMO knows that it can cobble together ad-hoc one-time agreements with non-network physicians or providers to perform limited services on the back-end ***and*** be relieved of their statutory duty to hold the patient harmless if the patient fails to choose among those providers, why would they put forth the effort to establish robust networks upfront?

For all of the foregoing reasons, TMA ***strongly opposes*** proposed Section 11.1611(d) as currently drafted.

3. **TMA's Recommended Modifications to Proposed Section 11.1611(d)**

In order to address the concerns that TMA has expressed above (i.e., in order to: (1) hold HMOs to their statutory duty under Insurance Code Section 1271.055; (2) avoid penalizing enrollees for rational decisions not to choose a "facilitated provider;" and (3) avoid disincentivizing HMOs from creating adequate networks), TMA recommends that subsection (d) be modified to read as follows:

(d) Provided that an HMO does not in any way delay the referral process set forth in subsection (c), [~~An~~] an HMO may facilitate a referral but may not require a referral to a specific non-network physician or provider when medically necessary covered services, excluding emergency care, are not available through a network physician or provider and an enrollee has received the referral from a network physician or provider.

(1) If an HMO chooses to facilitate the referral, the HMO must provide the physician or provider who requests the referral with a list of at least three non-network [~~preferred~~] physicians or providers with expertise in the necessary specialty who are reasonably available considering the medical condition and location of the enrollee.

(2) If the physician or provider who requests the referral selects a non-network [~~preferred~~] physician or provider from the list provided by the HMO, then subsections (e) – (g) of this section apply.

(3) If the physician or provider who requests the referral selects, with the agreement of the enrollee, a non-network physician or provider that is not included in the list provided by the HMO, then the provisions of subsection (c) still apply. [~~subsections (f) – (g), but not subsection (e), of this section apply to the claims of the non-network physician or provider~~].

The above recommendation is intended to clarify that the HMO enrollee (in conjunction with his or her referring physician or provider) still has the freedom to choose someone other than the person identified by the HMO's "facilitated" referral without incurring a negative impact on the coverage that is ***statutorily required*** to be provided to the enrollee under Insurance Code Section 1271.055, as well as subsection (c) of the proposed rules. The facilitation process should work as a short-hand approval process under Insurance Code Section 1271.055 and not as a method to circumvent the hold harmless requirement that is required under that statutory provision.

E. Proposed Section 11.1611(e)

Next, in Proposed Section 11.1611(e), the Department attempts to set forth the hold harmless requirements for the out-of-network services provided to HMO enrollees under the statutory exceptions.

TMA generally supports inclusion of the HMO's hold harmless requirements in the rules; however, TMA contends that subsection (e) needs to be modified to reflect that (consistent with TMA's recommendation above to modify the subdivisions in subsection d), the hold harmless agreement applies in subsection (d) across the board when an HMO facilitates a referral to a non-network physician or provider when medically necessary covered services, excluding emergency care, are not available through a network physician or provider and an enrollee has received the referral from a network physician or provider. In other words, it applies regardless of whether the enrollee accepts that facilitated referral or seeks a referral (that is not denied by the HMO) after recommendation of his own physician under subsection (c).

To that end, TMA recommends that subsection 11.1611(e) be modified to read as follows:

> An HMO reimbursing a non-network physician or provider under subsection (a), (b), ~~or~~ (c)<u>, or d</u> of this section must ensure that the enrollee is held harmless for any amounts beyond the copayment or other <u>lawful</u> out-of-pocket amounts<u>, if any,</u> that the enrollee would have paid had the HMO network included <u>network</u> [~~contracted~~] physicians or providers from whom the enrollee could obtain the services.

F. Proposed Section 11.1611(f)

Next, TMA strongly recommends that Proposed Section 11.1611(f) be amended to fully inform enrollees of the respective duties of the HMO and the enrollee with regard to payment for out-of-network services received under the statutory exceptions.

Specifically, TMA recommends the following:

> (f) After determining that a claim from a non-network physician or provider under subsection (a), (b), (c), or (d) of this section is payable, an HMO must <u>fully reimburse [</u>~~issue payment to~~<u>]</u> the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network

physician or provider. If the rate was not agreed to by the physician or provider, the HMO must provide an explanation of benefits to the enrollee that informs the enrollee [~~includes a statement~~]:

(1) That the HMO is required to fully reimburse the non-network physician or provider at the usual and customary or an agreed to rate;
(2) That the HMO's payment to the non-network physician or provider is at least equal to the usual and customary rate for the service;[~~,~~]
(3) That the non-network physician or provider may bill the enrollee for amounts beyond the amount paid by the HMO;
(4) That the HMO, and not the enrollee, is responsible for payment of any bill from the non-network physician or provider for amounts beyond the amount initially paid by the HMO;
(5) that the enrollee should notify the HMO if the non-network physician or provider bills the enrollee for amounts beyond the amount paid by the HMO so that the HMO may satisfy its obligation to hold the enrollee harmless as required under subsection (e) ,
(6) of the procedures for contacting the HMO on receipt of a bill from the non-network physician or provider for amounts beyond the amount paid by the HMO; and
(7) the number for the department's Consumer Protection Section for complaints regarding payment.

(1) Proposed Section 11.1611(g)

Next, in proposed Section 11.1611(g), the Department proposes the following language (which TMA has modified with suggested changes denoted with strike-throughs):

(g) Any methodology utilized by an HMO to calculate reimbursements of non-network physicians or providers for covered services not available from network physicians or providers must comply with the following:

(1) If based on usual and customary [~~or reasonable~~] charges, then the methodology must be based on generally accepted industry standards and practices for determining the customary billed charge for a service and fairly and accurately reflect market rates, including geographic differences in costs;
(2) If based on claims data, then the methodology must be based on sufficient data to constitute a representative and statistically valid sample;
(3) Any claims data underlying the calculation must be updated no less than once per year and not include data that is more than three years old; and
(4) The methodology must be consistent with nationally recognized and generally accepted bundling edits and logics.

TMA appreciates the Department's desire to put in place some guardrails for payment of non-network physicians in an attempt to limit potential gaming of the determination of usual and

customary, consistent with Insurance Code Sections 1271.055 and 1271.155. However, TMA seeks clarification from the Department on the intended impact of subsection (g).

TMA would strongly oppose the language in subsection (g) if the Department intends for payment rendered in accordance with subsection (g) to act as a substitute for the long-standing hold harmless requirements that HMOs must satisfy under Sections 1271.055 and 1271.155 of the Texas Insurance Code.

The Department itself has stated in the past that usual and customary or an agreed to rate may equate to a physician's full billed charge, if necessary to hold the HMO enrollee harmless. For example, in the Department's Biennial Report to the 80th Legislature, the Department stated as follows:

> … Further, because of the statutory directive to HMOs to "fully" reimburse the providers needed to fill network gaps at an agreed upon or usual and customary rate, the providers, almost exclusively hospital-based, can require payment of full billed charges, an amount that often exceeds typical contract rates.[19]

The Department would be acting against its long-standing interpretation of the statutory language (i.e, the requirement to "fully" reimburse providers) if it were to permit an HMO to discharge its statutory duty to hold the enrollee harmless simply by paying the usual and customary rate or using a methodology set forth in subsection (g) that fell short from holding the patient harmless (which, at times, will require payment of the full billed charge). The HMO has a statutory duty to pay the out-of-network physician or provider an amount sufficient to prevent the provider from balance billing the patient. To permit the HMO to pay otherwise, would be unacceptable. TMA would strongly oppose any attempt to promulgate a rule that undercuts the HMO's duty to hold the enrollee harmless.

Since the Department included an express provision regarding the application of the hold harmless agreement in subsection (e) of the proposed rules, TMA assumes that this was not the Department's intent with regard to subsection (g); however, TMA would appreciate clarification prior to providing further comment on this subsection.

Further, TMA would appreciate the Department's inclusion of a new subsection (h) that expressly states:

(h) Issuing payment using a required methodology under subsection (g) does not automatically discharge the HMO's duty to hold the enrollee harmless as required under subsection (e). The HMO must issue payment sufficient to prevent the enrollee from being balance billed.

[19] *Id.*

VI. Proposed Section 11.1611. Mandatory Disclosure Requirements and Plan Designation.

A. Proposed Section 11.1611(a)

Next, in Section 11.1611(a), beginning on line 3843, the Department proposes requiring an HMO to include in all evidence of coverage certificates, disclosures of plan terms, and member handbooks a specific notice that outlines basic enrollee rights under an HMO plan. TMA supports the Department's proposal to require such mandatory disclosures. However, TMA recommends that the Department make the following modifications to the proposed notice language.

First, TMA recommends that the Department add its contact information (or at least a link to its contact information) to the required notice language in lines 3856 to 3857, which reads as follows: "If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance."

Next, TMA recommends that lines 3859 through 3862 be amended to read as follows:

> If your HMO approves a referral for out-of-network services because no network provider is available, or if you have received out-of-network emergency care, the HMO must [~~, in most cases,~~] resolve the out-of-network provider's bill so that you only have to pay any applicable copayment, coinsurance, and out-of-network deductible amounts.

TMA assumes that the Department added the "in most cases" qualifying language to accommodate the exception set forth in its proposal in Section 11.1611(d)(3), lines 3809-3812, which specifies that the HMO is relieved of its statutory duty to hold the enrollee harmless if the enrollee does not choose one of three out-of-network physicians or providers "facilitated" by the HMO.

As TMA has urged the Department to delete the loss-of-hold harmless exception from proposed Section 11.1611(d)(3) for all the reasons detailed in Section V.D. of this comment letter, TMA also recommends that the Department delete the corresponding "in most cases" qualifying language from the mandatory disclosure provision.

Next, TMA recommends that the Department draft two new paragraphs at the end of the mandatory notice that should begin with the last sentence from line 3868-3870. These new paragraphs should explain to enrollees their rights and remedies when relying on materially inaccurate provider listings, as well as steps they'll need to take to avail themselves of those rights.

To that end, the last two paragraphs of the notice should read something similar to the following:

If you relied on materially inaccurate provider directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

In order to exercise this right, you will need to demonstrate that:

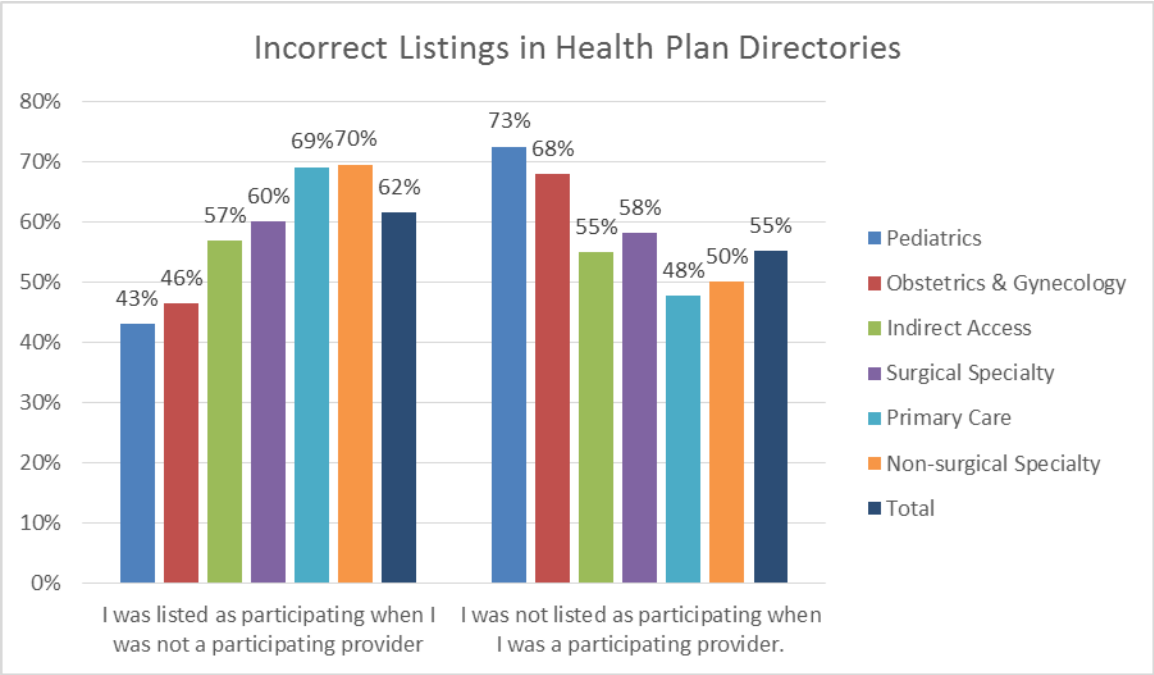
- you reasonably relied on a statement that a physician or provider was a contracted provider as specified in a provider listing or providing information on the HMO's website;
- the provider listing or website information was obtained from the HMO, the HMO's website or the website of a third party designated by the HMO to provide that information for use by its enrollees;
- the provider listing or website information was obtained not more than 30 days before the date of services; and
- the provider listing or website information obtained indicates that the provider is a contracted provider within the HMO's network.

In order to help you meet the above requirements, it is recommended that you:

- Check your HMO provider listing or website to verify the contracting status of a provider no more than 30 days before the date of service you are seeking with that provider;
- If the provider is listed as a contracted provider within your HMO's network: (1) print out a copy or take a screen shot of the page of the HMO website listing that shows the provider is listed in-network (Make sure the print out/screen shot includes a notation of the date you checked the listing); (2) maintain a copy of the paper provider listing that was obtained no more than 30 days before the date of service (Make sure to maintain proof of the date the listing was obtained, such as the envelope in which the listing was mailed to you); or (3) maintain documentation of the name, time, and date of the HMO representative who made the representation to you.
- If, after receipt of services, you learn that the provider who was listed as in-network was ***not*** actually in your HMO's network, provide the proof referenced in the second bullet to your HMO.
- If your HMO fails to pay your claim at the in-network level of benefits after receipt of the proof listed in this notice, you should file a complaint with the Texas Department of Insurance.

TMA contends that the addition of this language to the HMO mandatory disclosure notice will make the detrimental reliance provision in proposed subsection (f), line 3918, of the proposed rules much more meaningful to consumers. The Department must not only create a right, but must also provide a meaningful remedy for Texas consumers who have been misled by an inaccurate provider directory. A meaningful remedy will ***only*** exist if enrollees are informed sufficiently of how to exercise their rights.

TMA's preliminary results from its 2014 Annual Survey data indicate that inaccurate provider listings are a major, continuing problem in Texas. (See below for the preliminary results from TMA's 2014 Annual Survey)



Consequently, the Department should be proactive in taking steps to provide some relief to consumers from inaccurate listings and to arm the consumers with all information necessary to avail themselves of the Department's protections.

To that end, TMA also strongly recommends that the Department require an HMO to include the notice specified in this proposed Section in a ***prominent and conspicuous location*** in all provider listings, including any web-based provider listing for use by current and prospective enrollees. See, for example, adding this requirement to the listing-specific disclosure requirements proposed in subsection (g) of the rules at line 3932. TMA also recommends that HMOs be prohibited from placing the notice behind a firewall that might prevent prospective enrollees from viewing it.

B. Proposed Section 11.1611(f)

Next, in proposed Section 11.1611(f), the Department proposes creating a detrimental reliance provision for enrollees who reasonably rely on inaccurate provider listings. As stated above, TMA ***strongly supports*** the inclusion of such a consumer protection provision in the HMO rules. However, TMA seeks clarification from the Department regarding the language in this proposed subsection.

More specifically, in subsection (f), the Department's language states that "a claim for services rendered by a noncontracted provider must be paid in the same manner as if no contracted provider had been available under §11.1600 of this title,..." The particular provision of Section 11.1600 that is being cross-referenced is unclear to TMA. Thus, TMA reserves further comment on this section until it receives clarification on that language.

C. Proposed Section 11.1611(g)

Next, in proposed Section 11.1611(g), the Department sets forth the additional listing-specific disclosure requirements that HMOs must make. As indicated in Section VI. A. of this comment letter above, TMA recommends that the mandatory disclosure notice (with recommended TMA amendments) from proposed Section 11.1611(a)(1), beginning on line 3847, be added as an additional disclosure required under subsection (g) that must be prominently and conspicuously displayed (e.g., on the cover page) of any provider listing. TMA also recommends that HMOs be required to update their provider listings no less than monthly.

D. Proposed Section 11.1611(i)

Next, in proposed Section 11.1611(i), the Department incorporates language from the PPBP/EPBP rules, which requires an HMO to provide notice of a substantial decrease in the availability of contracted facility-based physicians at a contracted facility. TMA ***strongly supports*** the Department's inclusion of this provision. However, TMA recommends that the rules be amended to require the HMO to not only post notice on its website and update its web-based contracted provider listings upon substantial decreases of facility-based providers, but also to notify the Department at the same time. TMA contends that this Department notification will aid the Department in monitoring HMO compliance with the provisions of this subsection (and network adequacy in general).

E. Proposed Section 11.1611(j) and (k)

Finally, in proposed Section 11.1611 (j), the Department proposes language modeled after the language from the PPBP/EPBP rules that establishes separate plan designations for HMO networks that comply with the network adequacy requirements for hospitals (i.e., "Approved Hospital Care Network" or "AHCN") and networks that do not comply with the network adequacy requirements for hospitals (i.e., "Limited Hospital Care Network." or "LHCN"). TMA strongly supports the Department's proposal to include these provisions, as they are necessary for plan transparency and aid consumers in assessing the value and limitations of the product they have purchased (or are considering purchasing). TMA repeatedly argued to retain similar language in the PPBP/EPBP context and contends that such provisions are equally, if not more, important in the HMO context.

Additionally, in subsection (k) the Department proposes outlining steps that an HMO network previously designated as an Approved Hospital Care Network must take when it no longer complies with the network adequacy requirements for hospitals. Among those steps are requirements for the HMO to notify the Department in writing concerning the change in status,

cease marketing the plan as an AHCN, and inform all enrollees of the change of status at the time of renewal.

While TMA ***strongly supports*** inclusion of a requirement to make required notifications upon loss of an AHCN status, TMA recommends that the Department amend subsection (k) to: (1) decrease the period a plan may remain non-compliant to 15 days from the proposed 30 days in order to limit the potential for HMOs to mislead consumers regarding the strength of their hospital networks; (2) require the HMO to inform enrollees of the loss of AHCN status immediately (after the 15 day period), as well as at the time of renewal; and (3) promptly satisfy all requirements under subsection (j) regarding required disclosures as a Limited Hospital Care Network, which would require updating the HMO's evidence of coverage certificates, disclosure of plan terms, and member handbook as well as the cover page of any provider listing describing the network.

In order to implement these suggested changes, TMA recommends the following language:

> (k) Loss of status of an AHCN. If an HMO network designated as an AHCN under subsection (j) of this section no longer complies with the network adequacy requirements for hospitals under §11.1607 of this title and does not correct the noncompliant status within 15 [~~30 days~~] of being noncompliant, the HMO must:
>
> (1) Notify the department in writing concerning this change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box. 149104, Austin, Texas 78714-9104;
> (2) Cease marketing the plan as an AHCN; [~~and~~]
> (3) Inform all enrollees of the change of status immediately and at the time of renewal; and
> (4) Promptly satisfy all requirements under subsection (j) regarding required disclosures as a Limited Hospital Care Network.

VII. General Technical Comments

Next, TMA acknowledges that the informal working draft HMO rules are just that, a draft. However, we would respectfully request that the Department do a thorough review of the draft before moving forward to ensure that all terminology is used consistently throughout the document. TMA did not attempt to address all terminology inconsistencies in this comment letter, as we assume that the Department will make necessary changes prior to formally proposing the rules.

Additionally, TMA respectfully requests that the Department retain all the "relating to" parentheticals that are proposed for deletion in the rules, as the parentheticals enhance the readability of the rules (and therefore aid in HMO compliance).

VIII. Conclusion

Finally, in closing, TMA would like to once again reiterate the importance of TDI taking an aggressive stance in revisiting the HMO rules to ***strengthen***, rather than weaken, existing HMO network adequacy requirements. TMA strongly contends that in a closed network product, such as an HMO, the entire value of the product being offered to consumers is dependent upon the relative strength or weakness of the network available to enrollees.

TMA urges the Department to establish a regulatory framework that ensures that Texas consumers receive true value for the premiums they pay for HMO products by: (1) establishing robust network adequacy standards; (2) actively monitoring compliance with those standards; and (3) taking decisive action to enforce violations of those standards.

TMA does not believe that, in its current state, the informal working draft HMO rule proposal sufficiently accomplishes those goals. TMA, therefore, respectfully urges the Department to carefully consider the comments and concerns as set forth in this letter. Additionally, as stated earlier in the letter, Texas Medical Association staff (as listed below) request a meeting with TDI staff to continue a dialogue concerning these rules.

Once again, the ***Texas Medical Association and the undersigned Associations*** thank you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact the following staff of the Texas Medical Association: Kelly Walla, JD, LLM, TMA Deputy General Counsel; Lee A. Spangler, JD, TMA Vice President, Division of Medical Economics; Patricia Kolodzey, TMA Associate Director, Legislative Affairs; or Warren Cooper, TMA Director of Healthcare Delivery Systems; at TMA's main number 512-370-1300.

Sincerely,

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President, Texas Dermatological Society

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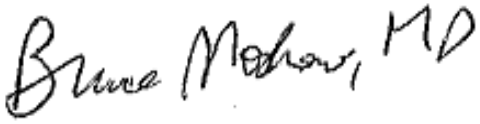
President, Texas Society of Anesthesiologists



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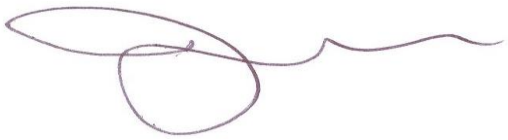

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