America's Health Insurance Plans

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March 16, 2018

The Honorable Representative Ivy Spohnholz
Chair, House Health and Social Services Committee
State House
Alaska State Capitol
Juneau, AK 99801-1182

Re: HB 193 – Balance Billing

Dear Representative Spohnholz,

I write today on behalf of America's Health Insurance Plans (AHIP) to express our concerns with HB 193, which takes the important step of banning balance billing by out-of-network providers but establishes a troublesome reimbursement mechanism.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Health plans develop provider networks to offer consumers and employers access to affordable, high-quality care. Health plan networks have been demonstrated as an effective means of containing costs and limiting patient out-of-pocket costs. When providers contract with carriers, patients benefit. Enrollees who receive services from a facility participating in their plan's network have a reasonable expectation that their providers at that facility will also be in-network. Unfortunately, patients may still be seen by an out-of-network provider because some interactions that patients have in a facility could be with ancillary service providers (e.g. anesthesia, radiology, and pathology) who do not have a contract with the health plan to provide covered services at in-network rates. Sometimes these providers, especially emergency room providers, refuse to contract with the facilities or insurers. We appreciate the sponsor's efforts to ban surprise balance bills and share his goals to provide that important consumer protection.

AHIP previously submitted comments to the Division of Insurance, agreeing with the Alaska Health Care Commission that the Division's current reimbursement mechanism based on out-of-network providers' billed charges is increasing costs. We are concerned the methodology being proposed here may also result in difficulties for carriers to contract with providers and develop robust networks.

The rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts in the state and instead continues to encourage health plans and providers to enter into mutually beneficial contracts.

Reimbursement to out-of-network providers should not be based on a methodology that uses billed charges – instead we strongly support a reasonable reimbursement based on what the market is already paying for those services (i.e. accepted rates, contracted rates, or government payment fee schedules). Billed charges are generally higher than the amount paid to providers under negotiated health plan contracts, or Medicare or Medicaid payment rates.

A study using Alaska-specific data from FAIR Health has shown average billed charges at up to 1617.4% of Medicare reimbursement rates.[1] The Alaska data shows a general trend of much higher billed charges that the national average. We believe that this data confirms the findings of the Alaska Health Care Commission that providers with high market share are pricing their services to ensure that they are below the 80th percentile and receive payment for their full billed charge, while artificially inflating costs for consumers across the entire health care system. [2]

The proposed approach harms insurers' efforts to build strong networks, hospitals' efforts to contract with providers, and consumers by increasing their costs, since cost-sharing is a percentage of the allowed amount. When providers can be virtually assured that they will receive their full billed charge by not contracting with health plans, this type of reimbursement methodology provides no incentive for providers to join networks, restricts the ability of carriers to manage costs through contracting with providers, and encourages already-contracting providers to remove themselves from networks. Using billed charges as a reimbursement rate would also create greater challenges for hospitals working to find and contract with providers of hospital-based services who will agree to participate in the same health insurance plans' networks as the hospital. Finally, requiring reimbursement at the billed charges amount would leave consumers open to higher cost sharing and charges that they should not have to incur.

Regarding a reimbursement mechanism based on what the market is currently paying for services, we appreciate that this bill provides other possible reimbursement amounts. However, the proposed reimbursement at 350% of Medicare is higher than anywhere else in the country. The Medicare reimbursement rates are already higher in Alaska than the rest of the country, in recognition of the increased costs of care. Requiring private plans to pay over three times what the government has already establishes as a fair payment amount is untenable. We believe that a reimbursement amount that high will have the same effects as discussed above for a billed-

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[1] *Charges Billed by Out-of-Network Providers: Implications for Affordability*. Page 13. America's Health Insurance Plans. September 2015. Available at https://www.ahip.org/wp-content/uploads/2015/09/OON_Report_11.3.16.pdf.
[2] *Findings and Recommendations 2009-2013. Alaska Health Care Commission*. Available at http://dhss.alaska.gov/ahcc/Documents/AHCC-Findings-Recommendations2009-2013.pdf.

charges based reimbursement – raising costs and destabilizing provider networks. We thus recommend that the benchmark specified should be significantly lower than the proposed 350% of the Medicare reimbursement rate.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue.

Sincerely,

Sara Orrange

Sara Orrange
Regional Director, State Affairs