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
Regional Director, State Affairs

NFIB

The Voice of Small Business

ALASKA

April 3, 2017

The Honorable Neal Foster, Co-Chair
House Finance Committee
Alaska State House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Bill 193

Dear Representative Foster,

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully express our opposition to House Bill 193. NFIB, the Voice of Small Business, is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues, not additional mandates.

For many small employers in Alaska insurance premiums for small groups or single coverage have, with the exception of this year, experienced continued jaw-dropping statistics of double-digit increases in the past few years. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates.

Unfortunately, HB 193 mandates specified coverage for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

This mandate does not specifically include the state employee programs. In fairness, if the state legislature does not believe it is a benefit important enough to mandate on its own programs, how can it be fair to mandate it on small employers and individual policy purchasers.

HB 193 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs or unions providing federally regulated health plans. Thus it creates a less fair business environment for small employers and a false promise to many Alaskans.

At a minimum, HB 193 should be amended to cover all public employees, including the state, the university, and municipalities.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Representative Jason Grenn

aetna

March 27, 2018

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

RE: House Bill 193 – "An Act relating to insurance trade practices and frauds; and relating to emergency services and balance billing."

Dear Representative Spohnholz,

Aetna respectfully requests your consideration of our comments for HB 193 (insurance trade practices and frauds; and relating to emergency services and balance billing). While HB 193 works to eliminate balance billing, it continues to put the patient in the middle and creates a concerning reimbursement methodology.

This bill seeks to protect health plan members from the negative financial consequences when they unsuspectingly receive care from an out-of-network provider at an in-network facility. In this type of situation the patient may be "balance billed" by an out-of-network provider that treated the patient at an in-network facility without the patients' knowledge of the provider being a non-participating provider in their health plan network. The non-participating provider can send surprise billings to a patient who did everything correctly in preparing for their treatment, seeking an in-network facility and provider. Often the surprise billing comes from providers that provide radiology, anesthesiology, pathology, neonatology or emergency department services. HB 193 attempts to address this practice but it does not outright prohibit balancing billing.

Health plans have long opposed the practice of balance billing and we share patients' frustration with medical surprise bills. The easiest solution is for providers to contract with health plans. At the very least, the patient should not be put in the middle when providers do not contract with carriers.

HB 193 also sets up a concerning reimbursement methodology on page 2 of the bill, lines 21 to 31. Using the words "the greater of the amount" on line 22 creates a situation where it would be rare that a plan would ever pay below the 80th percentile in Alaska. The 80th percentile is traditionally well over 350% of Medicare as outlined by this bill. We would suggest that lines 25 to 29 are completely struck to eliminate the 80th percentile in this legislation. As an organization, we have advocated for the removal of the minimum 80th percentile rule as the guideline for claims reimbursement. Aetna understands that the rule was put in place to

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protect consumers from excessive out-of-network bills in 2004 but now we believe the rule is having adverse effect on the market.

Increasingly, a small number of providers control a majority of the market share for medical specialties. This means that specialty care providers are often able to command up to 100% of their full billed charges since the methodology is focused on billed charges in the geographical area where services are performed. By its very nature, the 80th percentile rule means that the 80% of all providers (ranked in percentile 1-80) will receive 100% of billed charges. Unfortunately, the 80th percentile rule is driving up overall health care costs because health care providers know that incremental increases to their billed charges to just above the 80th percentile raises the overall charge profile. Overtime, the cost of health care services has dramatically increased far beyond the amount allowed by CMS.

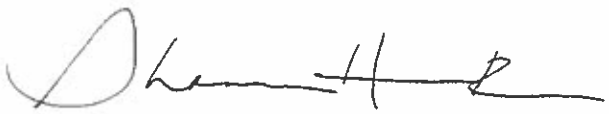
There are many examples of claims for non-participating providers where the charges, and thus, the 80th percentile allowable are in excess of 400% of CMS and beyond CMS allowable amounts. This rule is no longer protecting the customer and the purchasers of health care from unnecessarily high health care costs. In addition to higher non-par allowable amounts, the rule has also impacted the cost of care for contracting providers. If a provider knows that they can receive 400% of the CMS allowable amount if they are a non-participating provider then the incentive for entering into a health plan contract is greatly diminished.

Many states allow claims reimbursement for out-of-network services to be based on a percentage of Medicare – however, that percent of Medicare is not 350% as the bill suggests on page 2, lines 30 to 31. While a percent of Medicare for an out-of-network service is completely acceptable as a reimbursement methodology – this percent can be based on the amount that would be paid under Medicare for emergency service, excluding any in-network copayments or coinsurance with respect to an enrollee.

Aetna would like to work with you to ensure proper patient protections are in place while also encouraging physician participation in health plan networks. To that end we believe HB 193 should be amended to include language expressly prohibiting balance billing while eliminating the 80th percentile reimbursement rule.

Thank you for the opportunity to submit our concerns about HB 193.

Sincerely,



Shannon Butler
Senior Director of Government Affairs, West Region

NFIB

The Voice of Small Business®

ALASKA

April 6, 2017

The Honorable Sam Kito, Chair
House Labor & Commerce Committee
Alaska State House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Bill 193

Dear Representative Kito,

On behalf of the National Federation of Independent Business/Alaska, I wish to respectfully express our opposition to House Bill 193. NFIB, the Voice of Small Business, is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues, not additional mandates.

For many small employers in Alaska insurance premiums for small groups or single coverage have, with the exception of this year, experienced continued jaw-dropping statistics of double-digit increases in the past few years. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates.

Unfortunately, HB 193 mandates specified coverage for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

HB 193 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by many local governmental entities, public education entities or large employers who typically offer ERISA

programs or unions providing federally regulated health plans. Thus it creates a less fair business environment for small employers and a false promise to many Alaskans.

While we oppose mandates for many reasons, we appreciate that state employees will also be covered by this mandate. However, HB 193 should be amended to cover all public employees, including the university, and municipalities.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Representative Jason Grenn

House Labor and Commerce Committee — HB 193: Balance Billing
Len Sorrin — April 15, 2018

- Thank you, Chair Kito and Members of the Committee.
- For the record, I am Len Sorrin with Premera Blue Cross Blue Shield of Alaska.
- I am here today testifying **with concerns on HB 193**
- We share your commitment to ensuring that our members are not subject to balance billing or surprise billing by non-contracted providers. We understand that surprise billing imposes substantial and unexpected financial burdens on Alaskan families, many of who are already struggling.
- The challenge is to achieve that goal while moderating Alaska's health care premiums and costs, which are already among the highest in the nation. HB 193 can achieve the goal of banning balance billing, but it will exacerbate Alaska health care costs and premiums as a result of its use of the 80th percentile and 350% of Medicare as the likely rates to be paid to providers under the bill.
- The 80th percentile provision in the bill has been characterized as just one of three options in the bill. That much is true. However, the bill requires that carriers pay the highest of the three options. The 80th percentile will be the highest in the vast majority of cases. And in the rare case it is not, an even higher rate will be mandated.
- Make no mistake: the use of the 80th percentile as the highly likely mandatory choice for reimbursement will increase costs for Alaskans. Outside analyses confirm this.
- The recent study by Milliman makes clear that the 80th percentile standard has contributed to the unsustainable level of health care costs in Alaska. In 2015, the Alaska Health Care Commission recommended that Alaska "consider modifying the current usual and customary charge payment regulation to eliminate the unintended adverse pricing consequence."
- In addition to the problems presented by the use of the 80th percentile standard, the Department of Administration stated that the bill's reimbursement structure "could encourage providers to leave the networks and could result in long-term growth in the cost of services."
- Our experience reflects that concern. Let me provide you examples.

The 80th percentile regulation requires that it be updated twice a year. This creates a cost compounding impact that often exceeds the broader health care cost trend, increasing costs even further.

Premera's 80th percentile updates in 2017 resulted in UCR trends that were over 4 times higher than Premera's overall unit cost trend for 2017. That drives a real escalation in overall costs, increasing premiums and consumer out-of-pocket expenses

The guaranty of 80th percentile reimbursement for out of network care has also caused contracted rates to be far higher than they would be otherwise. Our contracted network rates in Alaska for the four hospital-based specialties are between 32% and 275% higher than in Washington as a percent of Medicare…and that is on top of Medicare rates that are already 25% higher here. Other specialties range upward of 1000% of Medicare.

- The challenge in determining fair reimbursement is to not disrupt what can be a very challenging environment for health plans to build networks in Alaska. Premera's Alaska network has grown in the last few years and continues to do so. But it's been very hard work, due in part to the attraction of the 80th percentile requirement for out-of-network care.

- That challenge can be greater when attempting to contract with hospital based emergency care, anesthesiology, radiology pathology, where members are unable unable to choose their provider. As a result, these provider types are guaranteed to see health plan members at an in-network hospital with or without a contract, and hence have less incentive than providers generally to contract with health plans.

- We want to continue our progress in building bigger and stronger networks for our members to access, offering members lower out of pocket costs.

- Reimbursing out of network care at the 80th percentile of billed charges as part of a solution to balance billing will impede that effort. While balance billing may be prohibited, Alaskans will be exposed to ever-increasing out of pocket costs as providers take advantage of the out-of-network reimbursement levels unencumbered by the risk of balance billing members. Member coinsurance costs overall will be higher when based on the 80th percentile standard than they would when based on a more market-based rate. Premiums will increase as well.

- We've proposed removing the 80th percentile with three options for reimbursement standards: the first two are the median health plan fee schedule for the specific specialty (as is in the present bill) and two different percent of Medicare options. The third option we've proposed is even simpler: it's simply the median contracted fee schedule.

- It's hard to come up with a better indicator of the actual health care market than one based on the median fee schedule to which providers and health plans have agreed. Markets are defined by a price or term to which parties agree.

- This is an opportunity for a balance billing solution for Alaskans to actually reflect the market in Alaska and maintain broad and affordable network access for Alaskans.

- We would also like to share with the committee concerns unrelated to the reimbursement methodology.

- First, we have suggested an amendment to the "hold harmless" section. The provision currently requires an insurer to "hold harmless" or ensure that a member does not incur costs in excess of what they owe for the in-network benefit under the bill. Premera will of course pay claims under the bill at the in-network benefit level and the member's responsibility under their contract with us will be limited to that amount. However, we have no ability to control whether a non-contracted provider will bill a member in excess of the amounts allowed under the bill. We would request that the provision be amended to reflect that reality.

- Second, we agree with the Department of Administration that the bill's intent is to apply to services rendered during emergency care. We also agree with their concern that the bill actually reaches far beyond those services. Separate from emergency services and emergency medical conditions, the bill's terms extend to any non-network provider who provides "services at an in-network hospital or ambulatory surgical center." That would apply to literally any service provided by an out-of-network provider at an in-network facility…for example a surgical service of any kind.

- This will result in a prohibition of balance billing far broader than intended and will also mandate the higher in-network benefit level required under the bill even for consumers who choose to see an out-of-network provider. **A prohibition on balance or surprise billing should protect consumers who are unable to choose a network provider and not those who are free to do so**.

- To resolve this, we suggest that "in-network hospital" and "in-network ambulatory surgical center" be linked only to "emergency services" and the treatment of an "emergency medical condition" to resolve any ambiguity on the reach of the bill.

- The bill also provides balance billing protection to any patient who has not consented in writing to balance billing when being referred to an out-of-network provider. Insurers have no way to know whether or not a referring physician was involved at some point, or whether a patient agreed in writing to be responsible for the additional costs of out-of-network care.

As a result, paying that claim correctly is difficult if not impossible. It would also be exceedingly rare for a referral to be involved in emergency care.

- Finally, the bill in any form will require changes to claims systems, changes to member benefit structures and a range of member and other communications. In addition, product and rate filings for 2019 will commence very shortly. In order to ensure that implementation is thorough, and that the impacts of the bill to all of these processes is well understood, we request an effective date of plans filed or renewed on or after January 1, 2019.

- Thank you. I would be happy to respond to any questions you might have.