February 23, 2018

The Honorable Mia Costello
Chair Senate Labor and Commerce Committee
Juneau, AK 99801

RE: Senate Bill 119 – Health Care Costs; Disclosure; Insurers

Dear Senator Costello,

Aetna respectfully requests your consideration of my comments for SB 119 (health care costs: disclosure; insurers;).

Aetna's primary concerns about the proposed legislation arise in Section 5 of the bill.

Section 5 "Access to payment information" through an interactive mechanism is a feature of Aetna's health insurance plans that already exists. Aetna already provides its members with robust transparency tools, allowing them easy access to estimates of the cost of their care. Aetna has transparency tools that provide members with an estimate of co-insurance, co-payment, out-of-pocket and out-of-network cost required by proposed subsection 21.96.205. While this tool allows members to estimate the cost of their services, it is important to remember we do not have contracts with out-of-network providers, so estimates are based on the coverage of the members' out-of-network benefits. However, we oppose Sec 21.96.210 in this section, which requires the addition of an incentive mechanism and is described more fully on page 8 of the bill.

A major feature of the bill is a proposed new incentive program often known as the "Right to Shop." SB 119 creates a mandatory version, which we believe will not work in Alaska. The premise of a "Right to Shop" bill is that consumers be given an incentive to find health care at a below average cost and then receive a cash (or similar) incentive to use that service.

The "Right to Shop" programs undermine the basic insurance model and do not take into account a highly regulated industry. Health care rates are not purely about cost. Quality of care and outcomes are equally important, but not taken into account if cost is the only variable. Additionally, this type of incentive program does not address minimum loss ratio laws and rebates (MLR), federal health savings accounts and rebates that are not allowed in some models, potential tax burdens to members who receive cash payouts, rate filings, etc.

The current insurance model creates strong provider networks that offer safe, quality care at a negotiated bulk purchase price and passes that value onto the employer providing insurance to

their employees. However, "Right to Shop" programs often undermine that goal, encouraging providers and facilities to stay out of network, making it much more challenging to build robust networks. A health insurer may reimburse more to a particular provider because of their specialty and proven outcomes. For example, if a parent is looking for a pediatric behavioral health specialist to help their child with an eating disorder, should the parent be burdened by shopping around for a cheaper provider or use the in-network provider that already has proven quality and safe outcomes? We want to ensure that members are not forced to shop for a cheaper provider or facility while trying to prepare for major life events such as heart surgery, cancer treatment or any other serious medical condition.

Implementing an incentive program creates a costly administrative burden on carriers to develop software and provide cash payments to members; our current systems are not designed to track this type of information. These programs often do not take into account that the premiums paid for insurance coverage are often paid for by the employer – yet the cash benefit goes back to the employee and not the employer who is paying for the insurance. Consequently, the majority of these theoretical savings go back to the consumer, while the cost of premiums would not be materially lowered in the future.

Currently Maine is the only state that mandates a similar incentive program, only addressing a small group of plans compatible with HSAs.

If the legislature adopts such a program, it may want to consider offering a pilot program first, or make the program permissible rather than mandatory. In the case of a pilot program, there would be a cost to the State in setting up the regulations or oversight of a new program, but it could be done on a smaller scale to evaluate true value.

If the provision of health care cost reduction is a primary motivation for this idea, the legislature may want to consider a change in the 80th percentile rule, which is a factor in maintaining Alaska's highest-in-the-nation health care costs.

Thank you for the opportunity to submit our concerns about SB 119.

Sincerely,

Shannon Butler
Senior Director of Government Affairs, West Region